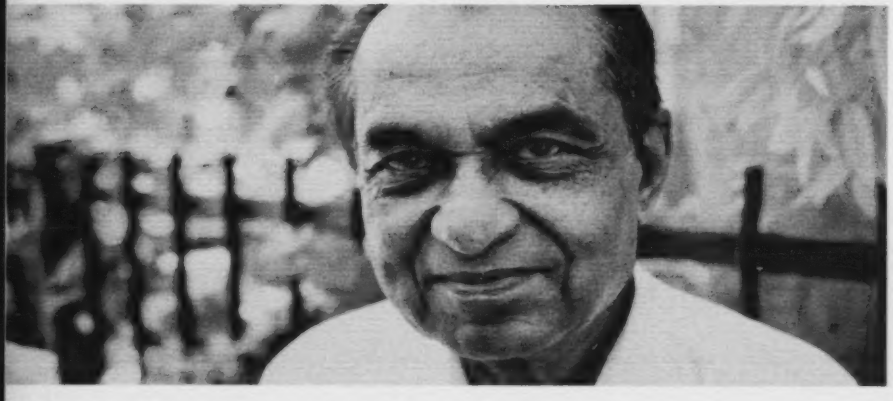
Central West **LHIN**



Together, Making Healthy Change Happen

Annual Report 2015 - 2016

June 2016

Ontario
Local Health Integration Network

MANDATE

The Central West Local Health Integration Network (LHIN) was established under the Local Health System Integration Act *(LHSIA)* 2006 and given authority to plan, fund, integrate and monitor the local health care system for the purpose of improving the health of residents who live in communities within the LHIN's geographic boundaries.

MISSION

To improve access to and the quality of, health services for residents of the Central West LHIN, through strengthened integration and coordination of health care services.

VISION

To create a health care system that helps people stay healthy, delivers good care when people need it and will be there for our children and grandchildren.

VALUES

Person-centred
Transparency
Integrity
Stewardship

GUIDING PRINCIPLES

The Central West LHIN has adopted the following principles to guide its planning processes:

- Equitable access based on patient/client need
- Preservation of patient/client choice
- People-centered, community-focused care that is responsive to local population needs
- Measureable, results-driven outcomes based on strategic policy formulation, business planning and information management
- Shared accountability among providers, government, community and citizens.

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WE ARE THE
PATIENT
EXPERIENCE!

TOGETHER, MAKING HEALTHY CHANGE HAPPEN

Maria Britto
Board Chair

Scott McLeod
CEO

A Message from the Board Chair and CEO

The Central West Local Health Integration Network (LHIN) is pleased to present its 2015-2016 Annual Report (AR 2015/16), showcasing progress and achievements made during fiscal year April 1, 2015 through March 31, 2016. This represents the third and final year of the LHIN's 2013-2016 Integrated Health Service Plan (strategic plan), otherwise known as IHSP 2013-2016.

Together, Making Healthy **Change Happen** takes its title from a shared sense of responsibility. It reflects an understanding and acceptance that by working together, as a collaborative team of health service providers (HSPs), community partners, residents and the LHIN organization, we can do so much more to bring about "healthy change" across the local health care system.

It follows that in 2015/16 and throughout the entire span of IHSP 2013-2016, the LHIN has successfully remained committed to the development of a more accessible and integrated local health care system as a team; a team responsive to the needs of residents and patients, while delivering better value for money. Notable results include:

- ✓ Significant investment across all sectors has resulted in a 21% ($156 million) increase in total LHIN funding over the past seven years.
- ✓ Five Health Links are now fully implemented across the LHIN's entire geographic area.
- ✓ 94% of Central West LHIN residents report having a regular family doctor.
- ✓ LHIN emergency departments (EDs) have lower proportions of low acuity visits when compared to the province.
- ✓ LHIN EDs have the lowest rate of visits among the 14 LHINs for a variety of minor conditions best managed by a family doctor.
- ✓ The regional Telehomecare (THC) program has helped to reduce rates of unnecessary ED visits and hospitalizations due to complications associated with diabetes.
- ✓ The LHIN's comprehensive long-term community capacity study of services for seniors has helped to identify current service gaps and potential future challenges related to a growing and aging population.
- ✓ 205 assisted living spaces have been added in Shelburne, Orangeville, Brampton, Etobicoke and Woodbridge.
- ✓ An investment of $1.4M has helped to support seniors with complex medical conditions who have experienced a recent loss of strength or mobility.
- ✓ Multi-year assess and restore funding has enabled the Central West Community Care Access Centre (CCAC) to provide ongoing targeted rehabilitation services to clients through the home independence program.
- ✓ There are now nine adult day programs in the Central West LHIN with a capacity to serve 248 seniors.

- ✓ $1.3 million has been invested in the expansion of home physiotherapy services for 2,036 additional physiotherapy clients, implementing 149 exercise and falls prevention classes in 36 locations across the Central West LHIN.
- ✓ The LHIN's regional THC program has enrolled over 1,800 patients. The In-Patient (IP) admission rate has dropped from 1.92 episodes/patient pre-program enrollment, to 0.46 episodes/patient after discharge; the average length of stay has decreased by more than a day post-discharge; and the ED visit rate has dropped significantly from 3.10 visits/patient pre-enrollment to 0.91 visits/patient post-discharge.
- ✓ The Central West LHIN took a leadership role in advancing the palliative and end-of-life care agenda through development of a joint "Pledge" for palliative and end-of-life care.
- ✓ Now recognized as an Indigenous Friendship Centre, the Central West LHIN looks forward to working with the Peel Aboriginal Network (PAN) on matters related to Aboriginal health.
- ✓ Constituted in 2014/15, the *Coalition pour les aînés francophones de Peel-Halton* has been providing a valuable Francophone lens when addressing both current and future service needs for seniors.
- ✓ Significant infrastructure investments have helped to address both current and future capacity needs at a variety of sites including Etobicoke General Hospital (EGH), Headwaters Health Care Centre (HHCC), Kipling Acres, Peel Memorial Centre for Integrated Health and Wellness, Rexdale Community Health Centre and WellFort Community Health Centre.

While these are but some of the many highlights attributed to the work associated with IHSP 2013-2016, understandably there is still a lot of work to do!

Accordingly, a notable highlight of 2015/16 was the development of IHSP 2016-2019, outlining the next phase of the LHIN's commitment and actions to renew the local health care system into one that meets the complex health care needs of a rapidly growing, aging, and culturally diverse population. IHSP 2016-2019 provides the Central West LHIN with the foundation necessary to meet new challenges, and to take a leadership role in advancing high-quality, patient-centred health care across Ontario.

Both residents and health care professionals alike place a high value on their health care system, and the need for it to be responsive to local communities. The Central West LHIN thanks the many HSPs, community partners and local residents who have actively engaged in helping to bring about healthy change across their local health care system.

With system building there will always be room for improvement. Nevertheless, the local health care system is further ahead today than when the Central West LHIN was first established a decade ago. Let there be no doubt, the LHIN is up to the challenges that lie ahead.

Together, we are making healthy change happen.

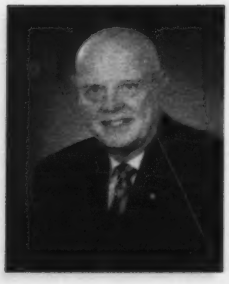
Kindest Regards,

Maria Britto
Board Chair, Central West LHIN

Scott McLeod
Chief Executive Officer, Central West LHIN

BOARD OF DIRECTORS

Maria Britto*
Chair
June 9/11 – June 8/14
June 9/14 – June 8/17



Hon. John McDermid*
Vice Chair
June 9/11 – June 8/14
June 9/14 – June 8/17

Adrian Bita
Director
May 6/15 – May 5/18

Lorraine Gandolfo*
Director
Oct. 27/10 – Oct. 26/13
Oct. 27/13 – Oct. 26/16

Suzan Hall*
Director
May 17/11 – May 16/14
May 17/14 – May 16/17

Gerry Merkley*
Director
June 17/10 – June 16/13
June 17/13 – June 16/16

Jeff Payne
Director
May 27/15 - May 26/18

Pardeep Singh Nagra*
Director
June 9/11 – June 8/14
June 9/14 – June 8/17

Ken Topping*
Director
Oct. 6/10 – Oct. 5/13
Oct. 6/13 – Oct. 5/16

** Denotes Reappointment*

GLOSSARY

ABP	Annual Business Plan
ALC	Alternate Level of Care
AR	Annual Report
BCH	Brampton Civic Hospital
BSO	Behavioural Supports Ontario
CAF	Coalition pour les aînés francophones de Peel
CCAC	Community Care Access Centre
CDPM	Chronic Disease prevention and Management
CHC(s)	Community Health Center(s)
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CSS(s)	Community Support Service(s)
CWPCN	Central West Palliative Care Network
ED(s)	Emergency Department(s)
EGH	Etobicoke General Hospital
EMR	Electronic Medical Record
FHG(s)	Family Health Group(s)
FHO(s)	Family Health Organization(s)
FHT(s)	Family Health Team(s)
FLS	French Language Services
H2H	Hospital to Home
HHCC	Headwaters Health Care Centre
HIP	Home Independence Program
HRM	Hospital Report Manager
HSP(s)	Health Service Provider(s)
HQO	Health Quality Ontario
IAR	Integrated Assessment Record
IDEAS	Improving and Driving Excellence Across Sectors
IHSP	Integrated Health Service Plan
IM	Information Management
IT	Information Technology
LHIN(s)	Local Health Integration Network(s)
LHSIA	Local Health System Integration Act
LTC	Long-Term Care
MOHLTC	Ministry of Health and Long-Term Care
OTN	Ontario Telemedicine Network
PAN	Provincial Aboriginal Network
SAM	System Access Model
THC	Telehomecare
InSTED	Short-Term Emergency Department Diversion
QBP(s)	Quality-Based Procedure(s)

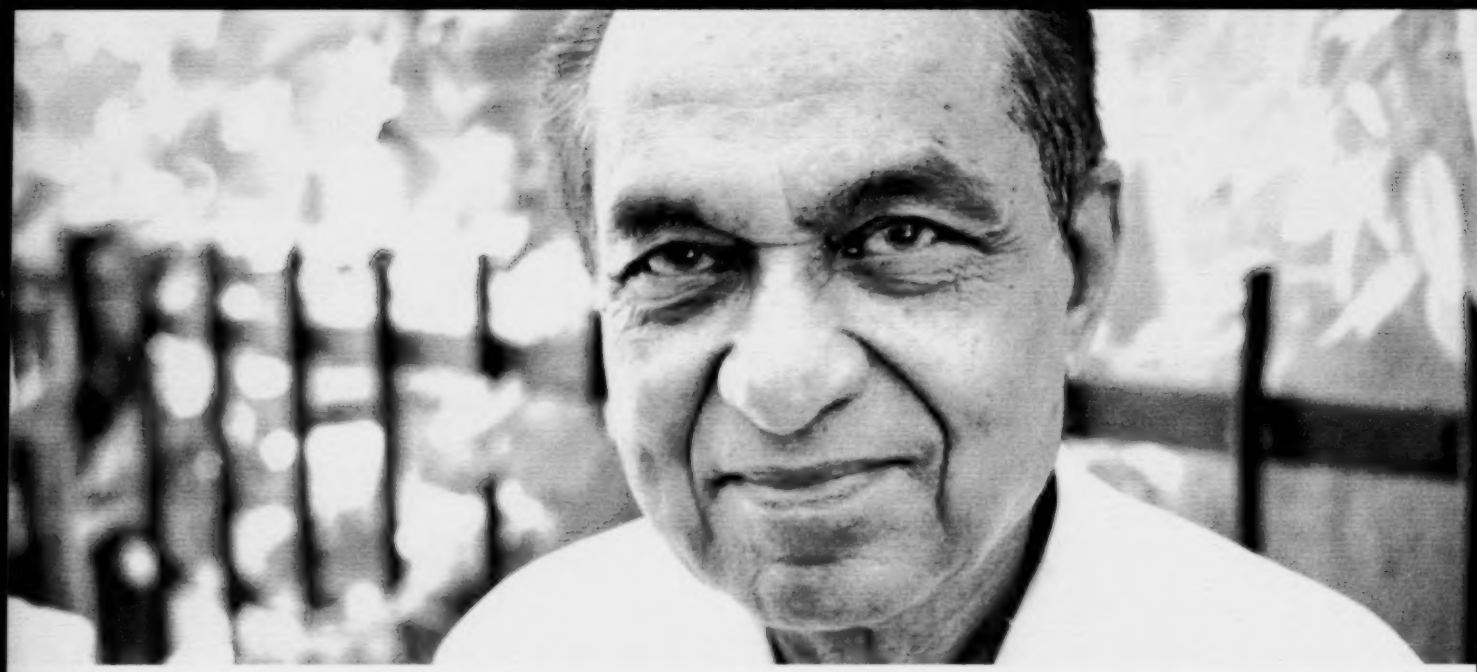
OVERVIEW

An extension of the Central West Local Health Integration Network's (LHIN's) 2013-2016 Integrated Health Service Plan (IHSP 2013-2016), Annual Report 2015-2016 (AR 2015/16) showcases the progress and achievements made for the fiscal year beginning April 1, 2015 and ending March 31, 2016.

It outlines how together, with local health service providers (HSPs) and the broader health care sector, the Central West LHIN has made notable gains in relation to the strategic directions identified in IHSP 2013-2016, and specific actions identified in ABP 2015-2016.

Highlights include:

- **Context** - Overview of Central West LHIN strategic directions; alignment with Ministry of Health and Long-Term Care (MOHLTC) and pan-LHIN priorities; population and health profiles of local LHIN residents.
- **Healthy Change** - Specific achievements and progress made in support of IHSP 2013-2016 and ABP 2015-16.
- **Central West LHIN Performance Indicators** - 2015/16 system performance and financial accountabilities established between the MOHLTC and Central West LHIN.
- **Engaging Central West LHIN Communities** - Summary of communications and community engagement activities during the 2015/16 fiscal year.
- **"The Road Ahead"** - Planning for and realizing the future needs of Central West LHIN residents and communities including capitol investmenst and IHSP 2016-2019.
- **Financial Statements** - Comprehensive outline of the Central West LHIN's audited financial statements including an independent auditor's report, statements of financial position, activities, changes in net debt and cash flows.



CONTEXT

1.1 Strategic Directions and Alignment

Aligned with Ontario's first Action Plan for Health Care, IHSP 2013-2016 focuses on four strategic directions and their related initiatives. It outlines the Central West Local Health Integration Network's (LHIN's) priorities with respect to placing patients first; building a more accessible and integrated local health care system, responsive to their needs while simultaneously delivering better value for money.

Improve Access to Care

- Primary Health/Family Health Care
- Chronic Disease Prevention and Management (CDPM) programs
- Mental Health and Addictions Services
- Community-based Services for Seniors

Build on the Momentum

- Aboriginal Health
- Diversity and Health Equity
- French Language Services
- Palliative Care
- Women and Children's Health

Streamline Transitions and Navigation

- Improve linkages with and among Primary Health/Family Health care and other providers in the health system
- Improve system navigation resources
- Increase system collaboration through use of information technologies

Drive Quality & Value

- Ensure an overarching LHIN quality framework
- Optimize use of health care resources to foster better care

1.2 By the Numbers

Population Profile

The Central West LHIN has grown substantially over the past decade, from 740,000 residents in 2006 to over 922,000 present day (seven percent of Ontario's population). With the highest projected growth rate in the province, over 17,000 new residents each year, the LHIN's population is expected to grow to almost 1.1 million by 2025. Not only is the Central West LHIN's population growing, it is aging. By 2025, the population of seniors (those aged 65 or more) is expected to increase by 62%, from 111,000 to 180,000.

One of the most geographically and ethnically diverse LHINs in the province, 86% of LHIN residents reside in urban areas, 8% in a suburban setting and 7% in rural communities. 47% of residents are immigrants, seven percent of whom are new to Canada within five years. The LHIN is also home to over 14,000 Francophone residents and 5,600 residents who self-report as aboriginal people.

Over the past five years, notable investments have improved access to a variety of health care programs and services in the Central West LHIN. Regardless of the challenges associated with the realities of a rapidly growing, ageing, and ethnically diverse population the LHIN, in collaboration with health service providers (HSPs) and community partners, remains committed to the planning, development and delivery of innovative and creative health care programs and services that meet the current and future needs of LHIN communities.

A GROWING POPULATION

Home to over

920,000

residents

Over **17,000** new residents each year

1.1M residents projected by 2025

AN AGING POPULATION

180,000 seniors (65 and older) expected by **2025**

an increase of **62%**

GEOGRAPHICALLY & ETHNICALLY DIVERSE

86% urban

7% suburban, 7% rural

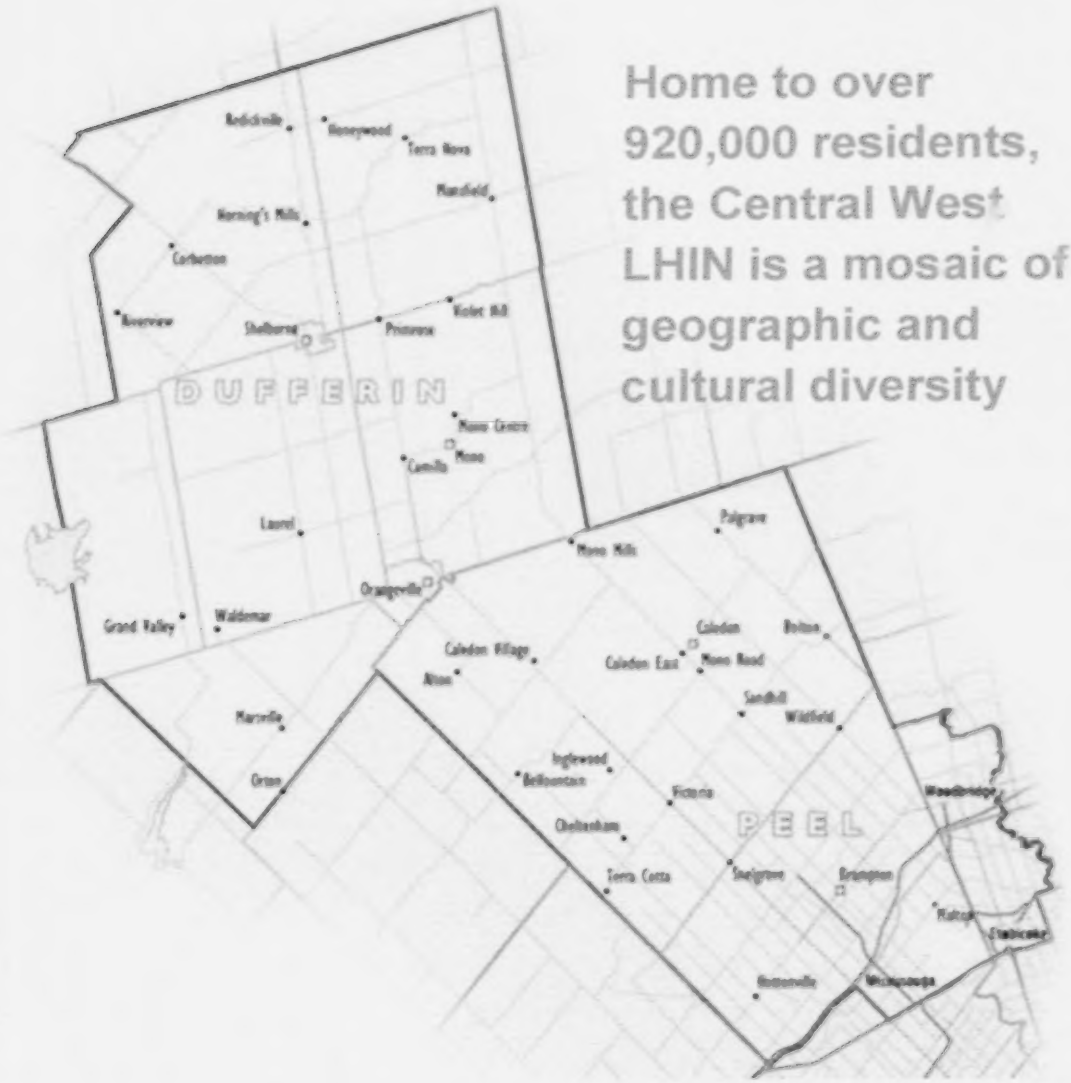
393,000

Immigrants

14,000 Francophone residents

5,600 Self-reporting

Aboriginal residents


Home to over 920,000 residents, the Central West LHIN is a mosaic of geographic and cultural diversity
DUFFERIN
PEEL
Arddcroft
Honeywood
Terra Nova
Mansfield
Horning's Mills
Corbetton
Riverview
Shelburne
Primrose
Violet Hill
Mono Centre
Mono
Camilla
Laurel
Orangeville
Grand Valley
Waldemar
Marcville
Orton
Palgrave
Mono Mills
Caledon
Bolton
Caledon Village
Caledon East
Mono Road
Alton
Sandhill
Wildfield
Inglewood
Bellmountain
Victoria
Cheltenham
Terra Cotta
Snelgrove
Brampton
Woodbridge
Vaughan
Mississauga

Health Profile and Access to Care

Timely and appropriate access to primary health care are key objectives identified in Ontario's first Action Plan for Health Care and IHSP 2013-2016. While almost all (94%) of LHIN residents report having a regular primary care provider, only 53% report the ability to see a primary care provider on the same or next day when sick. These indicators are particularly important for the Central West LHIN's population given the prevalence of certain chronic conditions and premature mortality.

Between 2009 and 2013 the proportion of Central West LHIN residents with at least one chronic condition decreased, and is significantly lower than the province. Prevalence decreased for every chronic condition with the exception of Chronic Obstructive Pulmonary Disease (COPD). The prevalence rate of COPD doubled in the Central West LHIN, from 2.1% to 5.0%, while Ontario's rate remained the same. Meanwhile, given the unique blend of an unprecedented growth in the senior population, combined with higher proportions of high risk ethnic groups residing within the Central West LHIN, the prevention and management of diabetes will continue to remain a local priority.

Many chronic conditions can be prevented or their onset delayed. Smoking, misuse of alcohol, excess weight, poor diet and physical inactivity are well established modifiable risk factors for many chronic conditions. The Central West LHIN has the lowest percentage of smokers (12%) and the second lowest proportion of heavy drinkers (12%) in the province. Conversely, rates for obesity (56%) and physical inactivity (54%) are higher than provincial values.

In 2015/16, there were 256,437 emergency department (ED) visits to hospitals in the Central West LHIN, an increase of 18% over 2010/11. With 27% more visits annually than the next busiest site, Brampton Civic Hospital (BCH) is home to the busiest ED in Canada. Hospitals in the Central West LHIN had the lowest rate of visits best treated in alternative primary care settings (a 30% reduction since 2010/11), meaning that the very high number of ED visits are appropriate. ED length of stay for patients discharged home from EDs in the Central West LHIN consistently meets provincial targets. However, length of stay for patients requiring admission to an inpatient bed is substantially higher than target, suggesting a need for continued investment in inpatient capacity.

In 2015/16, there were

256,437 ED visits

to hospitals in the Central West LHIN

↑ **an increase of 18% since 2010/11**

With 12% more visits annually than the next busiest site, Brampton Civic Hospital is home to the busiest ED in Canada.

Health Care Resources and their Use

Over the past seven years a 21% increase in base funding, totalling $156 million (from $727 million in 2009/10 to $883 million in 2015/16), has resulted in improved access to a variety of health care programs and services in the Central West LHIN.

In 2015/16, through a budget of $883 million provided by the MOHLTC, the Central West LHIN funded health service providers (HSPs) and community partners in the regions of Brampton, Caledon, Dufferin County, Malton, north Etobicoke and west Woodbridge.

- 2 hospital corporations across three sites... attending over 70,000 hospital admissions and 250,000 emergency department visits/year
- 1 Community Care Access Centre (CCAC)... serving over 32,500 clients/year
- 23 Long-Term Care (LTC) Homes ... providing an estimated 750,000 resident days/year
- 2 Community Health Centers (CHC) across 5 locations... delivering over 25,000 primary care visits/year
- 15 Community Support Service (CSS) agencies... offering services to over 40,000 clients/year
- 8 mental health and addictions organizations... providing over 20,000 interactions to local LHIN residents/year.

SIGNIFICANT sector investments* over the past seven years to improve the health and healthy outcomes of Central West LHIN residents.
*(*Increase from 2009/10 year-end, to 2015/16year-end)*

	$ 2009/10	$ 2015/16	$ Increase	% Increase
CCAC	77,593,209	115,820,159	38,226,950	49
Community Health Centres	6,668,770	12,182,882	5,514,112	83
Community Support Services *(*incl. Assisted Living)*	11,523,426	25,956,623	11,267,806	125
Hospitals	465,884,631	533,247,731	67,363,100	14
Long-Term Care	136,059,183	158,625,567	22,566,384	17
Mental Health and Addicitons	30,647,492	37,883,405	7,235,913	24
Total *($ in millions)*	727,403,702	883,716,367	156,312,665	21

HEALTHY CHANGE

"Healthy Change" reflects upon local initiatives; specific work and accomplishments related to the four strategic directions identified in the Central West Local Health Integration Network's (LHIN's) 2013-2106 Integrated Health Service Plan (IHSP 2013-2016). It outlines how, together with health service providers (HSPs) and community partners, the Central West LHIN has continued to place patients first throughout the past year.

2.1 Improve Access to Care

2.1.1 Improve Access to Primary/Family Health Care

Throughout 2015/16 the Central West LHIN continued to work with Family Health Teams (FHTs), Community Health Centres (CHCs) and other primary care practitioners practicing in other models of organized care, to ensure residents have timely access to multi-disciplinary primary care, provided in appropriate settings as close to home as possible. Of note, the LHIN is working with providers to develop systems and processes that will prevent or delay deterioration in the activities of daily living, which will reduce avoidable admissions to hospital and applications to Long-Term Care.

Current Status | Approximately 560 family physicians provide care throughout the Central West LHIN *(*Ontario Physician Health Data Resource Centre, 2013)*. Residents have access to six FHTs, two CHCs, 33 Family Health Groups (FHGs), 13 Family Health Organizations (FHOs), and over 180 individual fee-for-service practitioners. Attachment to a primary care physician is high, with 94% of residents of the Central West LHIN reporting they had a regular family doctor in 2015 *(*Health Care Experience Survey, December 2015)*. While most residents report having a family doctor, only 53% of residents reported that they could see their primary care provider on the same or next day when sick.

Residents do not appear to be turning to local emergency departments (EDs) for conditions that should be manageable within the community. Despite Brampton Civic Hospital (BCH) having the busiest ED in Canada and in Ontario (*137,818* visits in 2015/16, as compared to *123,132* at Humber River Regional) the three EDs in the Central West LHIN have lower proportions of low acuity visits compared to the province on the whole (Canadian Triage and Acuity Scale (CTAS) IV/V: 17% vs. 32%) and the lowest rate of ED visits among the 14 LHINs for conditions such as conjunctivitis, cystitis, otitis media and upper respiratory infections, that could be treated in primary care settings (1.1 per 1,000 population aged 1-74 years in 2013/14).

As one of the first of Ontario's 14 LHINs to implement five Health Links fully across its entire geographic area (Bolton-Caledon, Bramalea and Area, Brampton and Area, Dufferin Area and North Etobicoke-Malton-West Woodbridge), the Central West LHIN continued to play a key role in the collaborative design and implementation of Health Links in 2015/16.

HealthLinks

HealthLinks is an innovative approach to care, designed to drive positive outcomes for patients with complex conditions; patients who typically have multiple diagnoses and complex medication regimens, and whose circumstances significantly impair their ability to perform one or more activities in their daily living.

HealthLinks bring together multiple health care providers and their services within a local area - hospitals, family doctors, Long-Term Care Homes, community partners and other organizations – so that everyone involved in a patients circle of care, knows and understands their health goals, shares information, and works collaboratively to place the patients' needs first.

When multiple health service provider's work together as a team, patients receive better, more coordinated care. **HealthLinks** places patients at the centre of care, so they can feel supported and more confident about their health and healthy outcomes.

HealthLinks

Reduce...

- the need for emergency department visits and inpatient admissions
- avoidable re-admission to hospitals after discharge
- time for referral from primary care doctor to specialist appointment
- applications to long term care

Improve...

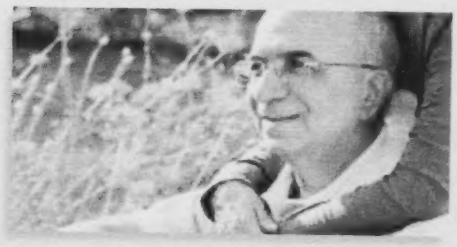
- patients' experience as they navigate in and around the health care system
- the patients' quality of life
- access to family care for seniors and patients with complex conditions.

Based on a common definition of complex high needs patients, those with four or more co-morbidities, ongoing identification of the Health Links patient population continued throughout 2015/16, with Health Links Care Coordinators continuing to develop tailored, individualized care plans for each patient.

It is also important to note that throughout 2015/16 the Central West LHIN continued to support the work of the Central West Primary Care Network. Led by the LHIN's Clinical Primary Care Lead this collective supports and develops diverse partnerships and strategies to engage local primary care practitioners, particularly in relation to initiatives such as Health Links.

Thanks to the collaborative work of Health Links, HSPs and community partners, the LHIN has increased the capacity of primary care providers to care for the needs of the most complex patients, improving their outcomes through comprehensive individualized care planning among local partners.

As the LHIN population grows and ages rapidly over the next several years, Health Links will continue to play an increasingly important role, addressing the capacity of primary care providers to care seamlessly for complex high needs patients and encouraging greater collaboration among local providers in order to improve outcomes.



Coordinated Care Improves Outcomes

"Nasir", an 82-year-old married man, who speaks no English, frequently visited his nearby hospital ED to obtain free acetaminophen.

A Care Coordinator and translator, from the local Health Link associated with the Central West CCAC, discovered that Nasir had been visiting the ED to relieve pain from an untreated hernia. He did not know to arrange for surgery through the specialist he had been referred to. Through the Health Link, the patient's primary care provider and CCAC Care Coordinator developed a tailored coordinated care plan to meet Nasir's pre and post-operative needs.

Following surgery and post-discharge, the care coordinator continued to work closely with Nasir and his family doctor to ensure receipt of appropriate care in line with the care plan and Nasir's changing needs.

Submitted by the Central West CCAC

**Names have been amended to ensure privacy*

2.1.2 Improve Access to Chronic Disease Prevention and Management Programs

Throughout 2015/16, the Central West LHIN worked with community partners to continue to improve the treatment and management of chronic diseases in the community, increasing capacity for the self-management of chronic conditions. This included efforts made to improve the coordination of regional diabetes services, and the ongoing expansion of education and self-management programs for chronic conditions including Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).

Current Status | The active client caseload for Central West LHIN residents attending local diabetes education programs continued to increase. Rates of unnecessary ED visits and re-admissions to hospital due to complications associated with diabetes (hyper and hypoglycemia) have decreased to below the established target rate of ≤198 per 100,000 populations. Meanwhile, the number of re-admissions to hospital within 30 days of discharge, for conditions related to diabetes, was at or below the evidence-based expected rate in all four quarters. These indicators reflect the collective success of the Central West LHIN's diabetes education and self-management programs.

The ongoing success of the LHIN's regional Telehomecare (THC) program is another strong example of how residents are using improvements in technology to self-manage care from the comfort of their own homes, while helping to enable better value through the reduction of unnecessary ED visits and hospitalizations.

otn telehomecare®

The Central West regional THC program makes it possible for residents with diabetes, CHF and COPD to self-manage their care from the comfort of home.

Patients are referred to the program from a number of regional partners and, through the assistance of technology, are monitored by THC nurses working from the host organization William Osler Health System (Osler).

Evaluations of the first THC patients revealed a **40%** reduction in ED visits and **49%** reduction in hospitalizations. These results demonstrate the ability of patients to better self-manage their conditions within their communities, avoiding and preventing unnecessary use of acute/ambulatory services.

At the end of 2015/16, the THC program had enrolled **1,728** clients and continues to have positive sustained results for patients and the healthcare system.

In collaboration with William Osler Health System (Osler) and the Wise Elephant Family Health Team, the Central West LHIN was pleased to present the 5th Annual Chronic Disease Prevention and Management Conference.

With development of IHSP 2016-2019 taking place throughout most of 2015/16, over 170 participants were challenged to use the conference as an opportunity to "*start thinking about tomorrow... today*," using the event as a forum for information gathering and knowledge exchange to inform the IHSP planning process, and plan for the future of the local health care system.

The conference also reaffirmed the LHIN's continued work with community partners to increase capacity for the self-management of chronic conditions in order to improve the treatment and management of chronic diseases in the community. Efforts made to improve the coordination of regional diabetes services will continue, and the expansion of education and self-management programs, including Telehomecare, for chronic diseases including CHF and COPD will move forward.

2.1.3 Improve Access to Mental Health & Addictions Services

In 2011, the Ontario government released Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy, a long-term comprehensive approach to transforming the mental health system. The first three years of this strategy focused on children and youth. In 2015/16, The LHIN expanded beyond the scope of children and youth to work with community and hospital partners in establishing the right continuum of adult, community-based services, easily accessible for all residents regardless of where they look or whom they ask for help.

Current Status | The Central West LHIN funds eight HSPs which collectively delivered over 20,000 mental health and addictions interactions to local LHIN residents in 2015/16. Services range in function, intensity and duration, and include case management, crisis response, counselling and treatment, early intervention, support within housing, residential withdrawal management, diversion and court support, social rehabilitation, recreation, health promotion and employment support.

Providers are being guided by a vision for Mental Health and Addictions services that emerged from a series of discussions among HSPs and the LHIN two years ago - *"high quality and seamless services that are easily accessed, efficient, available in a timely way, and meet the changing needs of people over their lifetime"*. The LHIN and HSPs discussed existing service capacity, strengths and challenges within the system, and determined priorities for program investments in both 2014/15 and 2015/16.

An investment of $3.9 million over the past two years has led to a number of notable gains within the Mental Health and Addictions sector.

$3.9 MILLION

Improved access to Mental Health & Addictions Services

- Reduced existing combined wait list for long-term case management and early intervention
- Integration of addiction consultation services for residents working with Health Links to develop a single, coordinated care plan.
- Enhancement of crisis services whereby clients and their families engage more meaningfully with crisis workers, and involvement of specially trained police officers who, teamed with a regulated health professional, intervene more appropriately.
- Adoption of person-centered and family-involved crisis planning approach consistent with local child and youth services' practice that defers to clients to decide more practical strategies for self-managing a crisis, increasing the likelihood that the crisis plan will be followed. Planned implementation is underway.
- Enhancement of family support and expansion of social rehabilitation/recreation, as a systemic way to support client access to and movement between services with varying levels of intensity as needed.
- Augmentation of front-line practitioners for short-term case management and brief therapy to respond more immediately to the presenting issue and to more readily assess need for longer term support.
- Efficient use of known housing stock to provide support within housing to 16 additional individuals and a planned approach for another 84 people, reducing the wait list by 25%.
- Capability for mental health and addictions staff to provide coordinated care in the ED, enabled through access to relevant, electronic clinical records (with client consent) at Osler and the Central West CCAC.

Canadian Mental Health Association / Association canadienne pour la santé mentale

Friends & Advocates Peel

family transition place

Peace Ranch

pchs Serving Diverse Communities

THE SALVATION ARMY

SHIP

William Osler Health System

Improving the quality and use of crisis services provides residents with an alternative to repeated use of the ED. It also enables first responders to better identify when it is necessary for residents to visit the ED. Accordingly, the LHIN's Short-Term Emergency Department Diversion (InSTED) matured throughout 2015/16, and is successfully providing clients with immediate short-term case management, often while they are still in the ED.

Data shows that the rate of repeat ED visits within 30 days for mental health has improved over the last year. The visit rate for Q4 14/15 through Q3 15/16 (the accountability period for FY 2015/16) is 15.6% better than both the provincial target of 16.3% and provincial performance of 19.2%.

Through reporting from Crisis Services and InSTED programs, there appears to be a correlation between these targeted community-based investments and the improvement in mental health repeat visits. For instance, Crisis Services are better identifying the need for a hospital visit through more comprehensive assessments. More of the clients recommended by Crisis Services for an ED visit are triaged as requiring acute care and are admitted, showing that the need for an ED visit was appropriately assessed and the visit was necessary. Clients have also self-reported a 60% reduction in repeat visits for mental health following engagement.

Meanwhile, in February 2016, the Canadian Mental Health Association Peel Branch (CMHA Peel) and the Caledon Detachment of the Ontario Provincial Police (OPP) announced expansion of 24.7 Crisis Support Peel into Caledon. The launch of this program with Caledon OPP builds on the success that 24.7 Crisis Support Peel has experienced over the last year in partnership with Peel Regional Police. Since program redesign and enhancement last March, 24.7 Crisis Support Peel has exceeded all expectations with almost 20,000 interactions (calls, visits, follow-ups) with individuals in mental health or addictions crisis. Despite this, the apprehension rate for the program is only 9% (under Section 17 of the Mental Health Act, police have authority to apprehend and take someone to hospital). Almost 100% of those clients have been admitted to hospital, reducing unnecessary ED visits.

Over the last three years, attention was focused on development of a System Access Model (SAM) for Mental Health and Addictions services, ensuring alignment to similar initiatives taking place in surrounding LHINs. There is full support to establish coordinated access that provides comprehensive information about support and treatment options based on the level of need, and that facilitates service transitions or interim support while waiting. The SAM was endorsed through consultations with persons with lived experience (consumers), children's mental health, development services, social services, family services, as well as within mental health and addictions sectors.

Scaled, phased implementation is planned for 2016, with one-time investments having helped to build the foundational operating aspects of the model i.e., business processes, clinical screening and assessment tools, service inventory, and pathways. With concurrent evolution of Health Links and coordinated care planning, and advent of the discussion paper Patients First: *A Proposal to Strengthen Patient-Centred Health Care in Ontario,* discussions have ensued regarding expanding access to care to a more integrated, holistic model across a broader array of services through use of information technologies.

Improving mental health services throughout the lifespan is one step toward ensuring the needs of Central West LHIN residents are placed first; that they remain at the centre of care, receiving better access, better quality and better value from their local healthcare system. Through early identification and intervention and enhanced community-based services, the LHIN is working to ensure that residents with mental health and addictions receive timely access to the most appropriate services as close to home as possible.

2.1.4 Improve Access to Community-Based Services for Seniors

In 2015/16 the Central West LHIN continued to work with funded community service providers to develop strategies that support seniors in the community, increasing their quality of life. This work is aligned with the province's Seniors Care Strategy and aims to reduce avoidable ED visits, hospital admissions and Alternative Level of Care (ALC) designations.

Current Status | The Central West LHIN funds community-based agencies that deliver services to support the independent living of seniors within the community. Services include social/safety visiting, congregate dining, adult day programs, transportation, exercise/falls prevention, chronic disease management, caregiver support, independence training, psychogeriatrics, assisted living, respite and palliative care. The LHIN also provides funding to the Central West CCAC to deliver nursing care, rehabilitation and personal support services, rapid response nursing, palliative care, community clinics and supportive living. The Central West CCAC also coordinates admission to 23 LTC homes across the LHIN.

24.7 Crisis Support Peel Expanded into Caledon

24.7 Crisis Support Peel is a community crisis service comprised of specially trained plainclothes police officers and mental health professionals. They provide timely response to adults (16 years and over) experiencing a mental health or addictions crisis; individuals having difficulties coping; and family, caregivers and friends needing support. The expansion of this mental health and addictions crisis service builds on the success of 24.7 Crisis Support Peel already in place in Brampton and Mississauga in partnership with Peel Regional Police.

24.7 Crisis Support Peel features an integrated team for maximum flexibility and responsiveness, comprised of mental health professionals and specially trained police officers. In keeping with other crisis models, officers are in plain clothes and drive unmarked vehicles, which can help to reduce the stigma surrounding mental illness and also helps to protect the privacy of the clients. This anonymity also allows clients to feel more at ease with officers, promoting a more open and trusting relationship and allowing the team to conduct a thorough and accurate mental health assessment.

▪ Capacity Planning

Over the next several years, the Central West LHIN is expected to experience unprecedented growth, higher than that of the province. By 2025, the total LHIN population is expected to surpass 1,099,000, of which nearly 180,000 are expected to be 65 years of age and older. With this rapidly growing and aging population, the LHIN continues to focus on those who are most in need of health care services, and has steadily prepared for this extraordinary growth and increased demand through innovative thinking and current and future planning.

Guided by recommendations in Dr. Samir Sinha's "*Living Longer, Living Well*" report, the Central West LHIN undertook a comprehensive, long term community capacity study of services for seniors, to identify current service gaps and potential future challenges within in the system.

This work represents a truly collaborative effort about a topic of mutual interest among the Central West and Mississauga-Halton LHINs, multiple HSPs, and community partners. The study places patients first by seeking to develop a community health services plan that meets the needs of a growing and aging population in both LHINs.

▪ Home and Community Care

The Central West LHIN funds 15 Community Support Service (CSS) agencies who collectively serve over 40,000 clients per year. The Central West CCAC serves over 32,500 clients per year. Over the past three years, use of home care services has significantly increased. The number of home care clients in Central West LHIN has increased by 15%, and home care hours have increased by 51%, indicating an increase both in the number and the acuity of home care clients. As the LHIN's population continues to grow and age, the local health care system is shifting from acute or hospital-based care, to community-based services. As the demand and need for these services continues to grow, the LHIN must consider the capacity of home care services that will be required to meet future demand. Throughout 2015/16, home and community care renewal aimed to keep seniors, particularly the medically complex and frail, safe, healthy and in their homes longer by ensuring appropriate access to care in the home and community sector.

As an identified best practice in seniors care, the Central West LHIN increased funding to assisted living programs, adding 205 assisted living spaces in Shelburne, Orangeville, Brampton, Etobicoke and Woodbridge, and bringing the total number of funded places to 629.

The Alzheimer Society of Dufferin County and Alzheimer Society of Peel received funds to expand joint "First Link" programs which support individuals living with dementia and their families.

A LHIN investment of $1.4M continued to help seniors with complex medical conditions who have experienced a recent loss of strength or mobility, making multi-year Assess and Restore funding available to the Central West CCAC's home independence program (HIP), which provides targeted rehabilitation services to frail elderly in their homes.

At the Peel Manor Adult Day Program, community funding was used to extend the hours of operation to accommodate additional seniors every day. There are now nine adult day programs in the Central West LHIN, with a capacity to serve 248 seniors.

New base funding was designated to expand adult day service hours, home care, respite programs, caregiver support programs, and Tele-Check programs.

In 2015/16 the LHIN continued to invest in the highly successful Behavioural Supports Ontario (BSO) program. A 2014 evaluation of the program indicated that behavioural support champions and psychogeriatric resource consultants embedded in Central West LHIN Long-Term Care Homes, were able to reduce responsive behaviours in identified residents by 47%. Additionally, results showed a significant decline in the use of physical restraints and in-home assessments that trigger worsening behavioural symptoms. Over 200 unique BSO program referrals were received in each of the first three quarters of 2015/16, while over 4,050 active patients and their caregivers have been supported during that same time period.

The Central West CCAC, Headwaters Health Care Centre (HHCC) and Osler, as well as the Ontario Telemedicine Network (OTN) and the Central West LHIN, completed development of the Hospital to Home (H2H) program. An innovative new model of care, H2H helps to improve clinical handoffs and information-sharing when patients leave hospital. This means that patients receive short-term nursing from the same care team after they return home. Right now, H2H is primarily supporting patients with urinary tract infections and cellulitis but will later expand to help those with more complex needs.

$1.3M Investment in Exercise and Falls Prevention

Throughout 2015/16, the Central West CCAC successfully implemented 149 Exercise and Falls Prevention classes across the Central West LHIN.

The class structure varies based on the frailty of seniors, with some classes focusing on patients with COPD, and some on stroke patients.

The Central West LHIN continues to work with the Central West CCAC and system partners (i.e. City of Brampton) and HSPs to increase referrals and engage seniors. Moving forward, the LHIN will continue to explore innovative ways to increase accessibility and attendance via telemedicine. In addition, a social determinants of health lens will be integrated to maximize seniors' social engagement and education through cross sector partnerships and collaborations.

Magic Abounds when Daycare and Seniors Home Share Same Roof

(With thanks to the Toronto Star)

In the second-floor lounge at Toronto's Kipling Acres Long-Term Care home, about 15 seniors in wheelchairs and walkers gather to the throbbing techno beat of "Gangnam Style" by Korean pop rapper PSY. Mary Offen, 82, lights up as the children arrive. Her wheelchair rocks while both feet tap to the music. "I love to dance and I love them," she says, grabbing the outstretched hands of 3-year-old Heaven Tulloch-Rankine. The children from the daycare centre downstairs revel in the adoration and, while some of them are timid at first, they are soon waving colourful pom-poms, shaking tambourines and cuddling up to the seniors.

Since the redevelopment of Kipling Acres, and with increased awareness of the benefits of intergenerational connections, daycare has played a larger role in the home.

The centre's playground opens onto a courtyard that serves residents, an adult day program, and a new seniors' community centre. Lounges with large windows on every floor of the 192-bed home also overlook the courtyard so seniors can watch the children play. The "move and groove" sessions along with bimonthly cooking, crafts, bingo and other activities are part of the home's regular programming to help build connections between the children and the seniors. This is in addition to Halloween costume parades, visits from Santa at Christmas and celebrations for other special days. Opportunities for spontaneous interaction are also encouraged.

Children learn through experience and at Kipling Acres, they get to experience another generation they might not see at home. "It was a nice surprise when I saw this," says Andres Quiroga whose daughter Yolanda, 3, and 20-month-old son, Isaac, attend the centre. "It's nice for my children to see someone like their grandfather," says Quiroga. His 75-year-old father lives in Colombia and the children haven't yet met him. "Yolanda is more kind to older people since coming here," he says. "She is more interested."

Linda Koslowski, whose 82-year-old mother Stella has Alzheimer's and has been a resident at Kipling Acres for just over a year, says having a child-care centre in the home has been a wonderful bonus. "My mother loves kids. When I take her out to the mall, we have to stop at every baby," says Koslowski. "It's just fantastic to have the children here."

And, while the arrangement offers wonderful opportunities for both children and seniors, it also benefits the staff, says Kipling Acres administrator Nelson Ribeiro. "It brings better outcomes in terms of the care," he said. "When you're having a difficult time or something is wrong and you see those little kids out there playing and smiling, it just makes your day."

2.2 Streamline Transitions and Navigation of the System

2.2.1 Improve Linkages With and Among Primary Health/Family Health Care and other Providers in the Health Care System

Through Health Links, the Central West LHIN is commited to supporting increased coordination in primary care settings, ensuring the provision of collaborative community-based care. Health Links is designed to drive positive outcomes for patients with complex conditions... patients who typically have multiple diagnoses and complex medication regimens, and whose circumstances significantly impair their ability to perform one or more activities in their daily living.

Current Status | As one of the first of Ontario's 14 LHINs to fully implement five Health Links across its entire geographic area (Bolton-Caledon, Bramalea and Area, Brampton and Area, Dufferin Area and North Etobicoke-Malton-West Woodbridge), the Central West LHIN continued to play a key role in the collaborative design and implementation of Health Links in 2015/16.

Based on a common definition of complex high needs patients, those with four or more co-morbidities, ongoing identification of the Health Links patient population continued throughout 2015/16, with Health Links Care Coordinators continuing to develop tailored, individualized care plans for each.

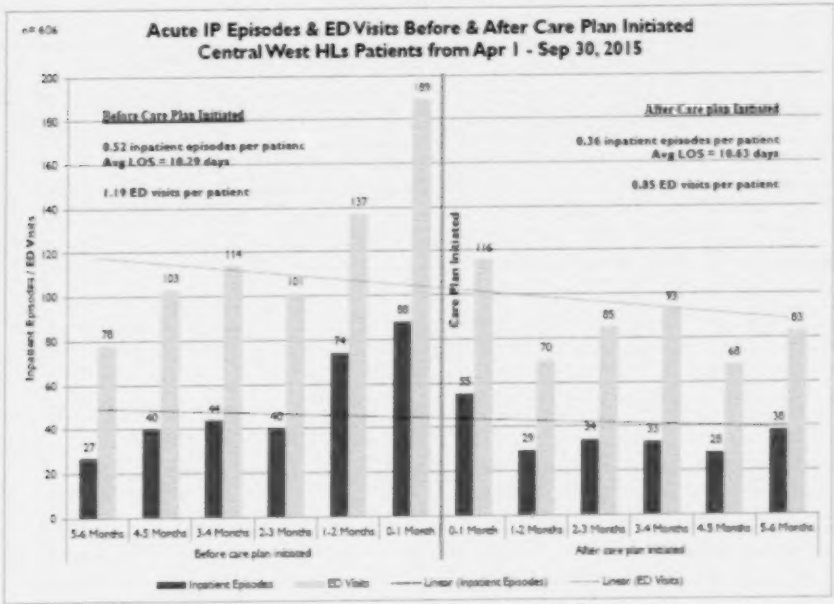
Continuing to have positive, sustained results for the patient and local health care system, the LHIN's regional Telehomecare (THC) program enrolled 1,728 patients. The inpatient visit rate dropped from 1.92 episodes/patient pre-program enrollment, to 0.46 episodes/patient after discharge. Average length of stay decreased, on average, by more than a day post discharge, and the ED visit rate dropped significantly from 3.10 visits/patient pre enrollment to 0.91 visits/patient post discharge. The Central West LHIN is currently working with OTN to integrate a health equity lens to the program to improve access to vulnerable and marginalized populations in the LHIN.

Notably, over the past year, eligible residents with CHF and COPD were better able to self-manage their care with the support of technology placed in their home through the regional THC program. Patients are referred to the program from a number of regional partners and, through the assistance of technology, are monitored by THC Nurses working from the host organization William Osler Health System.

Building upon work accomplished in 2015, Health Links will continue to encourage greater collaboration among existing local health care professionals. It follows that with improved coordination and information sharing, identified residents will receive faster care, spend less time waiting for services, and be supported by a team of health care providers at all levels of the health care system.

Central West Health Links Patients Activity Update
Acute Inpatient Episodes & Emergency Department Visits
April 1 to September 30, 2015

Key Findings: Inpatient (IP) episodes dropped by 30.6%, and Emergency Department (ED) visits dropped by 28.6% after care plan initiated. LOS did not change much pre and post care plan initiated (around 10 days)

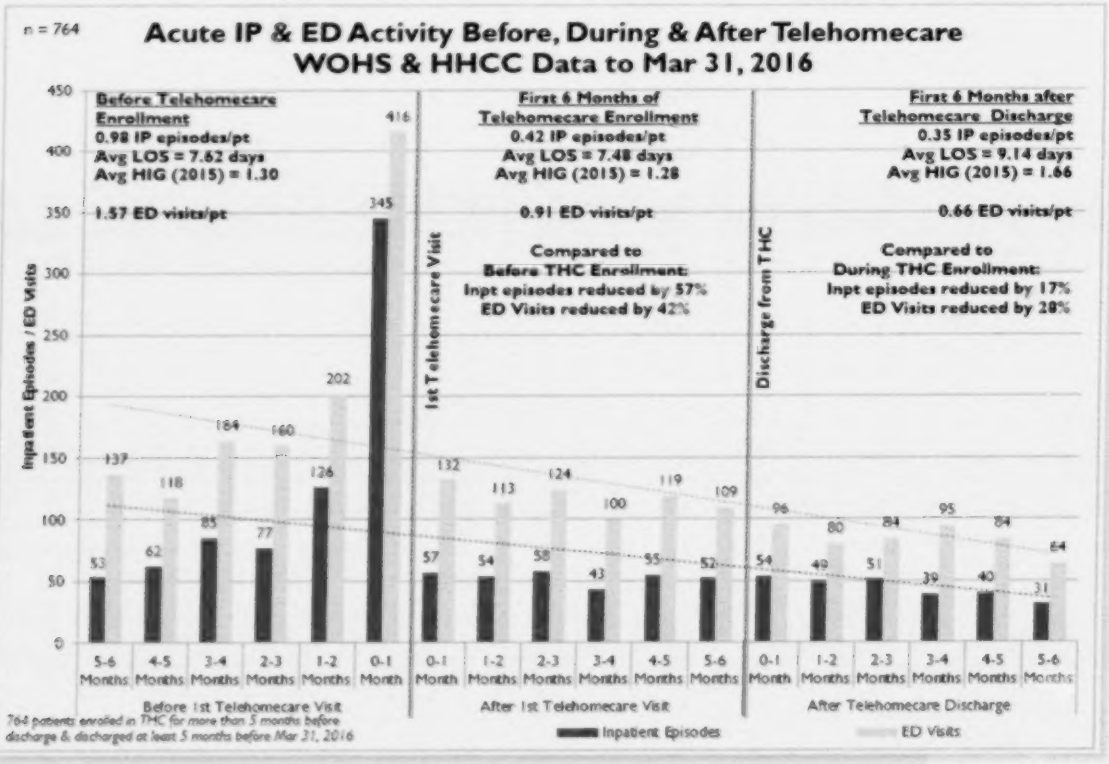

n= 606
Acute IP Episodes & ED Visits Before & After Care Plan Initiated
Central West HLs Patients from Apr 1 - Sep 30, 2015
Before Care Plan Initiated
0.52 inpatient episodes per patient
Avg LOS = 10.29 days
1.19 ED visits per patient
After Care plan Initiated
0.36 inpatient episodes per patient
Avg LOS = 10.63 days
0.85 ED visits per patient
Inpatient Episodes / ED Visits
Care Plan Initiated
5-6 Months
4-5 Months
3-4 Months
2-3 Months
1-2 Months
0-1 Month
Before care plan initiated
After care plan initiated
Inpatient Episodes
ED Visits
Linear (Inpatient Episodes)
Linear (ED Visits)

Sustained Indications for Health Links

Health Links are teams of local health providers who offer patients with complex conditions better coordinated care through the development of care plans that meet the specific needs of the patient to improve transitions among health care providers.

The following graph represents inpatient and ED utilization across Central West LHIN Health Links between the period April 1 2015 and September 30, 2015. 606 unique patients with individualized, coordinated care plans are represented.

A "before and after" analysis indicates that total inpatient episodes **decreased by 31%** and ED visits **decreased by 29%** after care plans were initiated.


n = 764
Acute IP & ED Activity Before, During & After Telehomecare
WOHS & HHCC Data to Mar 31, 2016
Before Telehomecare Enrollment
0.98 IP episodes/pt
Avg LOS = 7.62 days
Avg HIG (2015) = 1.30
1.57 ED visits/pt
First 6 Months of Telehomecare Enrollment
0.42 IP episodes/pt
Avg LOS = 7.48 days
Avg HIG (2015) = 1.28
0.91 ED visits/pt
Compared to Before THC Enrollment:
Inpt episodes reduced by 57%
ED Visits reduced by 42%
First 6 Months after Telehomecare Discharge
0.35 IP episodes/pt
Avg LOS = 9.14 days
Avg HIG (2015) = 1.66
0.66 ED visits/pt
Compared to During THC Enrollment:
Inpt episodes reduced by 17%
ED Visits reduced by 28%
Inpatient Episodes / ED Visits
1st Telehomecare Visit
Discharge from THC
5-6 Months
4-5 Months
3-4 Months
2-3 Months
1-2 Months
0-1 Month
Before 1st Telehomecare Visit
After 1st Telehomecare Visit
After Telehomecare Discharge
764 patients enrolled in THC for more than 5 months before discharge & discharged at least 5 months before Mar 31, 2016
Inpatient Episodes
ED Visits

Telehomecare (THC) in the Central West LHIN

The THC program enables patients with chronic heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD), who have visited the hospital multiple times, to self-manage their chronic conditions from the comfort of their own homes or local communities.

Ontario's THC program has demonstrated consistent outcomes with greater than 50% reductions in hospital ED and IP visits for over 9,000 patients.

Through 2015/16 the Central West LHIN THC program received 3,363 referrals, 1,728 clients were enrolled, and 1,467clients had been discharged. The above graph shows a notable decrease in both inpatient episodes and emergency department visits during and after implementation of THC.

In 2015/16, the post-discharge ED visit rate dropped by 71% and post-discharge inpatient admissions rate by 75%.

2.2.2 Improve System Navigation Resources

Throughout 2015/16 the Central West LHIN continued to work with HSPs and community partners to understand and address barriers to system access, developing integrated care pathways and care plans to help understand where and when to access needed health care after discharge from hospital. In doing so, the LHIN sought to partner with community and government agencies to strengthen system navigation and support the establishment and use of services, such as Health Links and Telehomecare.

Current Status | Length of stay has decreased and stabilized for patients discharged from the ED to home. Meanwhile, reducing wait times for patients admitted to an inpatient bed remains remains a challenge. It follows that there has been a need to direct attention on a system-level view to patient flow, both within the hospital and at points of transition between health service providers. Since its inception in 2013, the work of the Central West LHIN Patient Flow Core Action Group has focused on developing and implementing strategies that support this approach.

In 2015/16, the Central West LHIN remained committed to ensuring residents received improved access to care in the most appropriate settings. LHIN priorities are reflected across a number of priority areas including the Central West CCAC's expanded role of waitlist management, ongoing support for Home First, development of the Hospital 2 Home program, improving the quality and use of crisis services, further implementation of information technologies such as Telehomecare and Telemedicine, and the ongoing implementation of Health Links.

2.2.3 Increase System Collaboration through the use of Information Technologies

Information technology (IT) and information management (IM) are enablers for patient empowerment, and secure patient information exchange between providers. They reduce duplication and frustration by eliminating the need for patients to repeat the same information on multiple occasions to different health care professionals. And, they support patients, their caregivers and health care professionals to share information, coordinating services quickly and efficiently between transitions in care.

Current Status | In 2015/16, the Central West LHIN continued to make significant strides in planning and implementing enabling technology solutions. All hospitals in the LHIN are now live using Hospital Report Manager (HRM). HRM electronically delivers medical record reports (e.g. discharge summaries) and transcribed diagnostic imaging reports from hospitals, directly into the patients' charts in the Primary Care Physicians' Electronic Medical Record (EMR) system. Brampton Civic Hospital (BCH), Etobicoke General Hospital (EGH) and HHCC are continuing to expand electronic access of their hospital reports to primary care physicians and specialists through the use of the HRM product.

The Central West LHIN continues to have the highest EMR adoption rate in the province for primary care physicians at 87% (vs. 77%), and specialists at 62% (vs. 30%), enabling the greater sharing of consistent electronic information among HSPs.

The Integrated Assessment Record (IAR) allows client assessments to move with the client between HSPs, enabling participating HSPs to upload and view case histories from consenting clients. HSPs are better able to effectively plan, coordinate and deliver care. The tool also streamlines patient information so there is less duplication and faster access to services. Use of the IAR by HSPs in the Central West LHIN is stable at 63%. Providers include the Central West CCAC, 11 Community Support Service Providers, 7 Mental Health Service Providers and 23 Long-Term Care Homes.

Throughout 2015/16 the Connecting GTA (cGTA) project continued to work with HSPs to provide a single point of access to patient health information. Osler is live feeding data to the cGTA data repository, and viewing patient information from 11 early adopter hospitals and six CCACs located in the GTA. HHCC, along with 10 additional Central West LHIN HSPs, is included in the cGTA expansion phase, expected to go live in the 2016/17 fiscal year. Represented are HSPs from the Primary Care, LTC Home, Mental Health and Addictions, and Community Support Services (CSS) sectors.

In 2015, to better understand IM/IT in the community sector, a survey was issued to Community Sector HSPs across the Central, Central East, Central West and Mississauga Halton LHINs. The survey collected a broad range of data that has been populated into a database tool for analysis. The collated and cleansed data has been assessed and identification of a set of IM/IT opportunities that can be specifically targeted to home and community care HSPs have been identified. Implementation of identified opportunities are currently being assessed for future implementation.

The need for central intake processes and a referral management solution to support the intake processes, has been identified by multiple providers for multiple patient care pathways across the Central West LHIN. Work will continue in 2016/17 to identify and define patient care pathways that would benefit from a central intake model and support the implementation of a single referral management solution. Examples of care pathways include Health Link referrals, Mental Health and Additions referrals, Diabetes referrals, and Primary Care to Specialist referrals.

The Ontario Lab Information System (OLIS) has collected more than 85% of the provinces lab test results through connections with hospitals, community labs and public health labs. HHCC and Osler continue to populate OLIS with test results from their labs. Approximately 430 clinicians in the Central West LHIN can now view OLIS data for their patients through their EMR systems.

EMR adoption rates in the Central West LHIN are substantially higher than the provincial average.

Family Practice Physicians 87% vs. 77%

Specialists 62% vs. 30%

Ontario Lab Information System (OLIS) has collected more than

85% of provincial lab test results

Approximately 430 clinicians in the Central West LHIN can now view OLIS data for their patients through their EMR systems.

2.3 Drive Quality and Value

2.3.1 Ensure an Overarching LHIN Quality Framework

In 2015/16, the Central West LHIN remained hard at work supporting initiatives that improve quality and increase capacity for improvement. The LHIN incorporated patient/client experience into quality indicators, and developed a collaborative and integrated approach with HSPs to support the further development of quality improvement plans and undertake accreditation processes.

Current Status | The Central West LHIN is committed to the implementation of a local quality framework and agenda that places patients first, enhancing their experience with the local health care system while enabling improved outcomes.

All funded HSPs in the LHIN have signed Service Accountability Agreements (SAAs) that detail specific performance expectations to be achieved over the term of the agreements. In all of the accountability agreements it holds with HSPs, the Central West LHIN has incorporated a requirement for them to be accredited by March 31, 2017. Progress against this requirement is on track.

Meanwhile, in accordance with legislation, the LHIN has also required HSPs to submit Quality Improvement Plans (QIPs), which outline an organizations quality improvement goals for the following year. The Excellent Care for All Act 2010 requires all public hospitals, inter-disciplinary primary health care organizations, CCACs and Long-Term Care homes to develop and submit an annual Quality Improvement Plan (QIP). Beyond legislative requirements, to support system alignment and identify priorities for local quality improvement initiatives, the LHIN has additionally required that quality plans be completed by community support service agencies.

Next steps will involve collaboration with local HSPs to identify opportunities to align quality strategies and support for system level quality improvement aims - *Improve System Navigation, Improve Access to Mental Health and Addictions Services, and Improve System Navigation* - established by the LHIN in 2014/15. With implementation of a new three-year health system plan expected in 2016/17, the LHIN will determine the need to revisit, confirm existing, and/or establish additional quality improvement aims that reflect priories identified in IHSP 2016-2019.

The Central West LHIN Board of Directors maintained a focus on good governance in 2015/16. A highlight among health care professionals across the LHIN are the LHIN-hosted Governance and Leadership Forums. With 2015/16 representing a year of transition, the ability to engage with and harness the thoughts of over 180 health care professionals at one time, proved invaluable to the planning processes related to IHSP 2016-2019 and the MOHLTC discussion paper Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario.

2.3.2 Optimize Use of Health Care Resources to Foster Better Value

Hospitals beds are a valuable and often scarce resource. When people are unnecessarily admitted to hospital or are designated Alternative Level of Care (ALC) they are, by definition, not receiving the right care in the right place. Alternate Level of Care (ALC) refers to those patients who continue to occupy hospital beds after they have completed a course of treatment for which they were

admitted and no longer require the care associated with those beds. For a variety of reasons, these patients experience barriers to discharge from hospital.

In 2015/16, the Central West LHIN worked to improve access to acute care capacity. Specifically, the LHIN sought to provide more appropriate care to all residents by supporting expanded community-based services and by seeking improvements in admission, bed use, and discharge processes. Additionally, the LHIN continued to implement Health System Funding Reform (HSFR) initiatives that support best practice, cost-effective treatment and care.

Current Status | In 2015/16 the Central West LHIN had the highest proportion of high-acuity ED visits in the province. More specifically, when compared to the province (68%), 81% of all ED visits were triaged as high-acuity. 13% of all ED visits and 16% of high-acuity ED visits resulted in an inpatient admission. The LHIN met provincial ED wait time targets for patients discharged to the community from the ED, discharging 93% of low-acuity patients within four hours, and 93% of high-acuity patients within eight hours of presenting in the ED. These improvements are largely attributable to the *Pay for Results* program, now in its ninth year, which targets patience experience in the ED.

Central West LHIN ALC designations (1,479) and discharges (1,508) declined in 2015/16. A total of 20,065 ALC days were accumulated in 2014/15. Although the Central West LHIN maintains one of the lowest rates of inpatient capacity lost to ALC, work continues toward reducing ALC designations.

In 2013/14, funding for selected surgeries and diagnostic wait times shifted to a new Quality-Based Procedures (QBP) model in which HSPs are expected to deliver these procedures within funded amounts while maintaining or improving wait times. Since QBP implementation, the LHIN has experienced improvement in wait times for diagnostic imaging. Notably in 2015/16, 72% of patients received computerized tomography (CT) within the provincial access target of 28 days.

Governance and Leadership Forums... Together, Making Healthy Change Happen

With respect to magnetic resonance imaging (MRI), the Central West LHIN has moved from rates below 20% in 2010/11, to performance above 71% in 2015/16. In 2015/16 more than 89% of cancer surgeries and over 87% of cataract surgeries were consistently performed within provincial access targets.

Opportunities for improvement remain. Wait times for hip and knee replacement continue to grow and the number of residents receiving these surgeries within the provincial access target continues to decline. The LHIN has worked with its hospitals to improve performance, but the overwhelming demand for these procedures continues to outstrip the supply.

Health System Funding Reform

The Central West LHIN and many local HSPs now operate in a patient-based funding environment known as Health System Funding Reform (HSFR). HSFR is a new way of funding hospitals and community providers based on the burden of illness and care needs in the community, where patients actually go for care, the quality of providers' care, and the efficiency of that care. It represents a more consistent approach to funding health care across the province that also incents the best possible care in the most efficient way possible, to drive quality and value. Throughout 2015/16 and moving forward, the Central West LHIN intends to further support the provincial HSFR strategy, and work to better align funding to need and evidence-based practice.

Throughout 2015/16, the Central West LHIN continued to advance the provincial HSFR strategy through active participation in the pan-LHIN HSFR Advisory Committee, and the MOHLTC's renewed HSFR governance structure and implementation of annual HSFR initiatives with local HSPs. The Central West LHIN continued to identify and monitor the health service needs of the local community, and work towards the goal of putting patient's needs first while aligning funding and delivery of high quality care in an affordable and sustainable manner.

HSPs in the Central West LHIN actively supported HSFR quality improvement and change management strategies by participating in three cohorts of the provincial *Improving and Driving Excellence across Sectors* (IDEAS) program, and continued to collaborate on implementation of Quality- Based Procedures (QBPs). To date HSP leadership have established a number of QBP implementation teams that have or are currently implementing strategies for alignment with best practice and health outcomes. Planning is underway to work more closely with Health Quality Ontario (HQO) that will further align QBP and quality goals locally.

In September 2015, the MOHLTC announced six innovative projects focused on the patient experience that would test innovative integrated approaches of service delivery and new integrated funding models intended to improve the delivery of quality, evidenced-based care to patients. Hospital to Home (H2H): The Central West Integrated Care Model was selected as a 3-year proof of concept project. H2H is a model of care that will better enable seamless patient transitions from the hospital to the community. It is a joint initiative of the Central West CCAC, HHCC and Osler, working in partnership with OTN.

In Q3 2015/16, H2H began to enroll patients from Osler's Etobicoke General Hospital (EGH) site, with implementation at HHCC and Osler's Brampton Civic Hospital (BCH) site in Q4. In its first year, H2H will support patients diagnosed with cellulitis and/or urinary tract infections requiring short-term nursing interventions. In years two and three, the model will be expanded to more complex care using both nursing and interdisciplinary models, including palliative care, stroke,

chronic diseases, and appropriate post-surgical procedures. At the writing of this report, 282 patients had been enrolled in the H2H model of care, and a total of 1,857 nursing visits had been conducted by the end of the fiscal year. Early data suggests that this intervention is having positive impacts on ED visits, hospital admissions, average hospital Length-of-Stay (LOS), average community LOS, as well as the average number of nursing visits in the community, when compared to the pre-intervention period. The H2H model supports a strategic shift to more community-focused, scheduled care, supporting people to receive care in their homes or in the community, helping prevent unnecessary emergency department visits and hospital admissions, shortening the acute length of stay for admitted patients, providing greater continuity of care and enhancing the patient experience.

2.4 Build on the Momentum

Throughout 2015/16 the Central West LHIN devoted time, attention and resources to long-standing initiatives that are aligned with provincial directions and priorities.

2.4.1 Aboriginal Health

The Central West LHIN has continued to actively engage local Aboriginal communities, with the aim of better understanding local health and service delivery issues from wellness to mental health, chronic disease management, and palliative care perspectives. The Central West LHIN is committed to building capacity within the health system to ensure Aboriginal communities receive culturally competent care; care that recognizes and is tailored to particular social, cultural, and linguistic needs.

To further understand and recognize the importance of cultural competency, in relation to Aboriginal health, Central West LHIN staff and Board Members and select HSP staff members have completed the Indigenous Cultural Competency training program offered through the Provincial Health Services Authority in BC, and have actively taken part in Métis information and training sessions.

LHIN CEOs and Aboriginal Health Leads took part in the Provincial Aboriginal LHIN Network Planning Conference, establishing strategic priorities to advance Aboriginal health and inform the development of IHSP 2016-2019.

During 2015/16, the LHIN partnered with the Métis Nation of Ontario (MNO) Credit River Métis Council and the Mississauga Halton LHIN to hold Powley Day Celebrations at the Island Lake Conservation area. Thanks to this partnership, voyageur canoe trips and other community health activities were provided to as many as 60 participants. It was an excellent opportunity for the MNO Credit River Métis Council to showcase and support their culture and identity with Métis and non-Métis peoples alike.

The Central West LHIN in partnership with the Mississauga Halton LHIN, the Credit River Metis Council, the Dufferin County Cultural Resource Centre and the Peel Aboriginal Network held engagement sessions on the development of IHSP 2016-2019 and discussion paper Patients First: A proposal to strengthen patient centred care in Ontario. This laid the groundwork for the drafting of inaugural Terms of Reference for the Central West LHIN and Mississauga Halton LHIN Indigenous Health Advisory Circle.

2.4.2 Diversity and Health Equity

Throughout 2015/16, the LHIN's Diversity and Health Equity Core Action Group continued to explore and apply effective ways to improve cultural competency and minimize gaps for vulnerable populations. In partnership with the MOHLTC, Health Quality Ontario (HQO) Regional Diversity Roundtable, and Peel Newcomer Strategy Group the Central West LHIN identified key areas of focus including a need to further integrate use of the Health Equity Impact Assessment (HEIA) tool. HSPs are now using the tool to plan improved access to care for marginalized populations. Ongoing training is being supported by the LHIN to ensure sustainable and meaningful use of the tool.

Championed by the LHIN, a host of nine organizations representing primary care, acute care, and community mental health and addictions services are taking part in a pilot project to collect sociodemographic information from those who enter and use local health care services.

In 2015/16, all acute and community providers submitted progress reports on the implementation of health equity plans. Submission of yearly progress reports ensures consistent movement towards the integration of health equity practices, and improvement of equitable access to care.

The Central West LHIN also took a leadership role in developing a pan-LHIN collaborative with the mandate to discuss local and provincial opportunities that advance the work of health equity and improve population health for the residents across Ontario.

Building Bridges for Inclusive Care in Peel

The Region of Peel was proud to have been selected as one of 18 Provincial Service Collaboratives, a key source of input for years one to three of the MOHLTC's ten-year Mental Health and Addictions Strategy. Produced in 2015, the video *Building Bridges for Inclusive Care Care in Peel* highlights the coming together of various faith communities and mental health service providers, to improve recognition of mental health issues and access to supports by children and youth. While the provincial strategy continues to move forward beyond year three, the work of this collaborative has continued to make an impact beyond its original mandate.

Partnering for Change

The introduction in 2015 of Partnering for Change (P4C), a new therapy program that sends therapists directly into school classrooms, has been praised by parents and school officials for giving children with special needs access to occupational therapists without having to leave the comfort and convenience of their classrooms.

Originally developed at McMaster University to bring therapy to the children who need it, P4C is a collaboration with schools, so that teachers can work alongside therapists and learn some of the therapists' techniques to help the students on an ongoing basis. Thanks to P4C, organizers say they have been able to do much more with the same amount of resources. P4C is now working in more than 60 schools across Peel, Halton and Hamilton-Wentworth. And more school districts have expressed an interest in adopting the model.

Supporting New Syrian Canadians

Of the many happenings that captured the world's attention in 2015/16, perhaps none was more compelling that the Syrian Refugee Crisis. A unifying humanitarian issue, health care professionals across the Central West LHIN took pride and a great deal of satisfaction in their ability to collectively help, when their skills and compassion were needed the most. Upon arrival at Toronto's Pearson International Airport, located within the Central West LHIN, our newest Canadians made their way to final destinations in communities across Canada, many of which are now calling Central West LHIN communities home.... **WELCOME!**

2.4.3 French Language Services

With a vibrant francophone community, the Central West LHIN continued to work to enable better access to local health care services in French in 2015/16.

Together with LHIN HSPs and Reflet Salvéo, the local French Language Services (FLS) planning entity, the Central West LHIN ensured the application of an FLS lens to local and provincial planning including IHSP 2016-2019 and Ontario's *Patients First*: Action Plan for Health Care. The LHIN also worked with other system partners, to improve the quality of data on the Francophone population, supporting the development and use of common FLS indicators.

The LHIN continued to work closely and collaboratively with Reflet Salvéo, particularly in areas related to engaging the francophone community, capacity building and service planning. Priorities and actions were identified and outlined in a Joint Annual Action Plan between Reflet Salvéo and the Central West, Mississauga Halton and Toronto Central LHINs. Year-end reporting by each identified for FLS HSPs reported an increase of 34%in the number of Francophone residents who requested service in French from 2014/15.

Successful Collaboration for the Francophone Seniors Coalition

Ongoing development of a collaborative care project between Reflet Salvéo and the Central West LHIN continued in 2015/16.

Known as the *Coalition pour les aînés francophones de Peel-Halton*, the CAF brings together the collective efforts of le Club du Bel Âge, la Retraite Active et le Cercle des Aînés Noirs Francophones de l'Ontario to help address both current and future service demands for Seniors from a Francophone perspective.

Working together as a collaborative makes it easier for Francophone seniors to become better informed about activities and services offered to them in the community. It also helps to improve overall service delivery.

The work of the coalition is supported by the Central West and Mississauga Halton LHINs, Reflet Salvéo and Le Cercle de l'amitié, Well Fort Community Health Services, Oasis Centre des Femmes, l'Équipe de Santé familiale Credit Valley and le Réseau franco-santé sud de l'Ontario.

2.4.4 Palliative and End-of-Life Care

Made up of all palliative care providers who care for residents throughout the Central West LHIN, the Central West Palliative Care Network (CWPCN) guided the development of palliative care services in the Central West LHIN throughout 2015/16, and has been doing so since 2009. These services are delivered in local hospitals, private homes, LTC Homes, and in one residential and one community hospice. One adjacent residential hospice and two community hospices also provide care to residents of the Central West LHIN.

In 2015/16 the Central West LHIN was proud to take a leadership role in advancing the local palliative and end-of-life care conversation by further developing a joint palliative end-of-life care "Pledge".

Introduced to over 300 health care professionals at the CWPCN Annual Conference, the Pledge is inspired by a quote taken from the Canadian Hospice Palliative Care Association's Living Lessons® report. It reflects a collective commitment to deliver on the promise of providing outstanding palliative care.

Recognizing a sense of collective responsibility, conference participants shared their "personal pledge" toward the delivery of outstanding palliative care across the Central West LHIN by posting their commitments on "pledge boards" placed outside of the main conference hall for public viewing.

"At some time, in some way, we will all face the end of life. And most of us share a common hope: that when death comes to us or a loved one, it will be peaceful and free of pain. We hope to face death surrounded by those we love, feeling safe, comfortable and cared for."
OUR PLEDGE
Together we will deliver outstanding palliative care.

In 2015, the Ministry of Health and Long-Term Care (MOHLTC) announced a major change in the structure of palliative care networks. A new Ontario Palliative Care Network (OPCN) has been created, along with a provincial secretariat that will be responsible for providing provincial oversight of 14 LHIN palliative care networks.

The Central West LHIN recognizes that the delivery of outstanding palliative care is essential for individuals and families throughout the LHIN's highly diverse population. Through a reconstituted CWPCN, the LHIN will work to ensure:

- capacity is enhanced for palliative care in the home and community
- diverse palliative care needs of the community are met
- public and health care providers understand options available for palliative and end-of-life care
- virtual technology is used as a value-add means to bring care closer to home.

2.4.5 Women and Children's Health

Throughout 2015/16, the LHIN worked with local providers to improve the quality of, and access to, women and children's health services, while at the same time aligning its work with provincial initiatives. The Central West LHIN worked with the Provincial Council for Maternal Child Health (PCMCH) to improve access to care for children with medical complexities. The LHIN is also currently involved in the development of the local Special Needs Strategy for Peel and Dufferin in alignment with a provincial strategy to improve services for children and youth with special needs in Ontario. This required collaborating across sectors, working in partnership with providers funded by the Ministry of Child and Youth Services (MCYS), Ministry of Community and Social Services (MCSS), Ministry of Education (MEDU), and MOHLTC.

South Asian Community Outreach Forum

Hosted by Bethell Hospice, Heart House Hospice and the Punjabi Community Health Services the Central West LHIN was once again proud to be part of the annual South Asian Community Forum on palliative and end-of–life care.

The session attracted over 150 participants who, through interactive discussions were able to learn more about what types of palliative and end-of-life services are currently available in their local communities.

Understanding the important culture-specific aspects of palliative care helps to inform the planning process in order to create a system that is both patient-centred and responsive to culturally-specific needs.

PERFORMANCE

The Ministry-LHIN Accountability Agreement (MLAA), sometimes called the Ministry-LHIN Performance Agreement, is an agreement between each of Ontario's 14 LHINs and the Ministry of Health and Long-Term Care (MOHLTC). It outlines the obligations and responsibilities of both organizations with respect to the planning, funding and integration of local health care services.

The MLAA includes measures used to assess the LHINs performance which, from time-to-time, are modified according to the changing priorities of the health care system. As of fiscal year 2015/16, the MLAA lists 24 measures in three categories

- **Performance:** Provincial targets have been established for the 14 performance measures, based on best practice and clinical evidence where possible. LHINs must report to the ministry on their performance against these targets on a quarterly and annual basis.

- **Monitoring:** Provincial targets have been established for some, but not all, of the 8 monitoring measures. LHINs are not required to report on monitoring measures, but they often provide important supplemental or explanatory information about the performance measures.

- **Developmental:** Provincial targets have not been established for the 2 developmental measures. These measures focus on emerging priorities of Ontario's health system, and their definitions are subject to change as they are developed.

CENTRAL WEST LHIN MLAA INDICATORS
2015/16 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial			LHIN		
			2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (ytd)***	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (ytd)***
1. Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	86.55%	85.28%	92.23%	83.58%	88.43%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	93.21%	93.66%	96.52%	95.19%	95.86%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	30.00	19.00	31.00	21.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	10.48	9.97	10.85	11.25	10.57
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.28	4.07	3.50	3.80	3.68
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	40.37%	38.41%	25.35%	33.37%	33.34%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.08%	74.60%	79.03%	80.38%	71.51%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.63%	79.97%	47.47%	71.76%	67.50%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	78.18%	79.14%	47.88%	60.08%	72.19%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.15%	14.16%	7.14%	6.06%	6.02%
11	ALC rate	12.70%	13.70%	14.12%	13.98%	6.26%	6.00%	5.53%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.33%	20.28%	24.74%	26.09%	25.02%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.39%	33.42%	27.59%	30.52%	31.84%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.62%	16.51%	15.90%	15.61%	16.01%
2. Monitoring Indicators								
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	86.56%	88.03%	85.86%	87.47%	88.55%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	94.00%	95.00%	NA	NA	NA
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	87.37%	88.09%	89.21%	88.77%	87.08%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	15.00	14.00	20.00	20.00	16.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	12.00	13.50	12.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	4.58	12.86	5.25	1.12	3.48
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	80.87	235.64	279.11	69.25	207.98
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	45.55%	46.58%	55.41%	54.22%	55.96%

*FY 2015/16 is based on the available data from the fiscal year (Q1-Q3, 2015/16)

**FY 2015/16 is based on the available data from the fiscal year (Q1-Q2, 2015/16)

***(YTD) Year-to-Date

The following section provides an overview of MLAA indicators grouped by which sector of the health care system they are measuring.

Primary Care

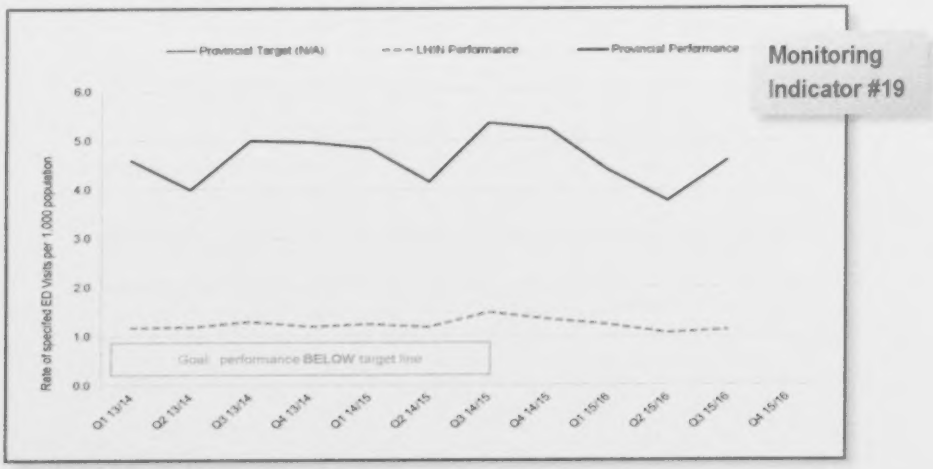
Primary care is the day-to-day healthcare provided by family doctors and other health care professionals in the community. Primary care measures in the Central West LHIN are included as monitoring indicators, but do not have target performance associated with them.

Monitoring Indicator #19: **Rate of emergency visits for conditions best managed elsewhere per 1,000 population** | Rate of low acuity emergency visits that could be treated in alternative primary care settings for patients aged 1-74 years. Conditions include:

Conjunctivitis (pink eye)
Upper Respiratory Infection (cough/cold)
Otitis Media (earache)
Cystitis (urinary tract infection).

For patients who are not seniors and have no other complications, the four conditions listed above are not emergencies and should usually be treated in a setting other than the emergency department (ED). If patients are arriving at EDs for these conditions, it indicates that these patients did not have adequate access to primary care, either because they do not have a primary care provider, because they were not aware of the availability of their primary care provider, or their primary care provider was not available to them within a reasonable time.

In 2015/16, the Central West LHIN rated best in the province for this indicator, suggesting that LHIN residents have better mechanisms for dealing with urgent, but non-emergent, health care issues than most Ontarians.

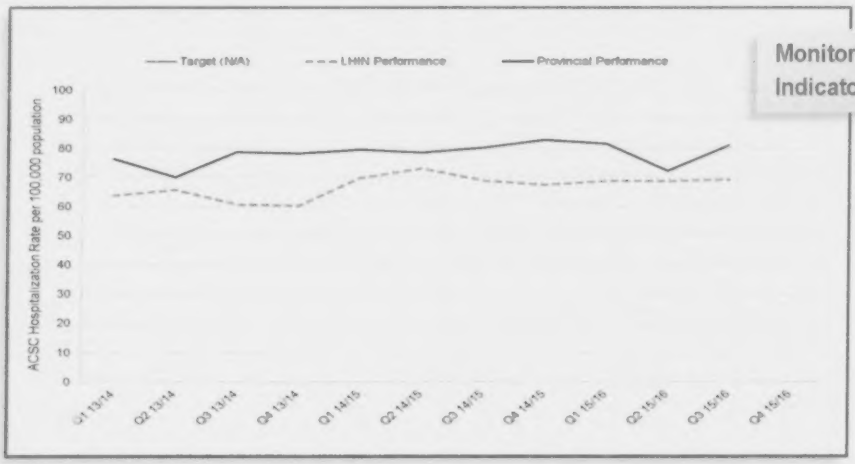


Monitoring Indicator #20: **Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*** | Rate of hospitalization for ambulatory care sensitive conditions per 100,000 population age < 75. Conditions include:

- Grand mal status and other epileptic convulsions
- Congestive heart failure (CHF) and pulmonary edema
- Chronic obstructive pulmonary disease (emphysema and bronchitis)

- Asthma
- Diabetes
- Hypertension
- Angina.

When managed effectively in primary care and/or the community, ambulatory care sensitive conditions should not lead to hospitalizations. Hospitalizations for these conditions are often referred to as avoidable hospitalizations and indirectly measure the ability of the health care system to manage chronic conditions, access to primary care and care in the community. Optimizing management of these conditions can potentially contribute to both improved patient health outcomes and more efficient resource utilization. In 2015/16, the Central West LHIN ranked 4th out of 14 LHINs for this indicator.



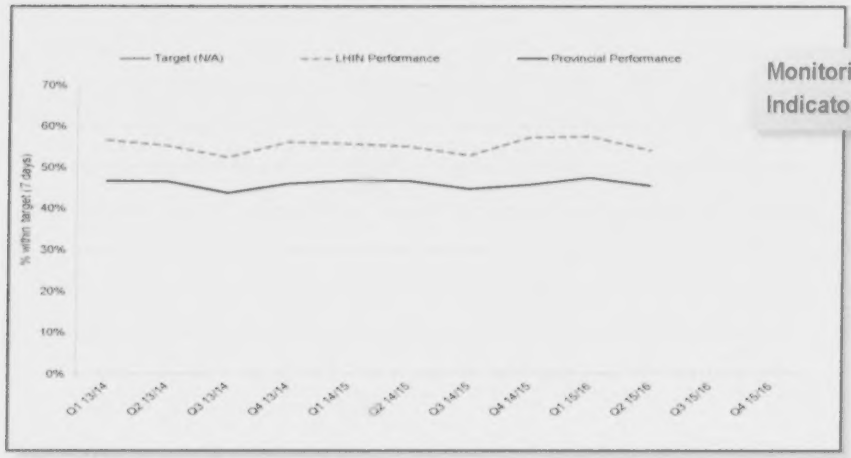
Monitoring Indicator #20

Monitoring Indicator #21: Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge | Percentage of patients with a hospital stay for specified conditions who saw their physician within 7 days of discharge. Conditions include:

- Acute myocardial infarction (age 45+) (heart attack)
- Cardiac conditions other than heart attack (age 40+)
- Congestive heart failure (age 45+)
- Chronic obstructive pulmonary disease (age 45+) (emphysema and bronchitis)
- Pneumonia
- Diabetes
- Stroke (age 45+)
- Gastrointestinal disease.

Chronic conditions that are not managed appropriately are a cause of substantial avoidable interactions with the health care system. When a patient with a chronic condition experiences an exacerbation of that condition, it often requires an ED visit and admission to an inpatient bed. The combination of appropriate care while in hospital, seamless handoff of care to community providers, and appropriate follow-up and preventative care in the community can prevent recurrence of exacerbations and repeated admissions to either the ED or the hospital.

One of the most important steps in this preventative sequence is connection with the patient's primary care provider shortly after discharge from the hospital. In 2015/16, the Central West LHIN rated best in the province for this indicator.



Monitoring Indicator #21

System Integration and Access

Performance Indicator #14: Readmission within 30 days for selected Health-Based Allocation Model Inpatient Grouper (HIG) conditions | This indicator measures what proportion of patients being treated for chronic disease(s) required subsequent admissions to hospital after an initial hospital stay. This performance indicator is closely related to the monitoring indicator immediately above—the chronic conditions being addressed are the same, and follow-up with a primary care provider after discharge is one of the interventions likely to prevent readmission. In 2015/16, the Central West LHIN ranked 6th out of 14 LHINs for this indicator.

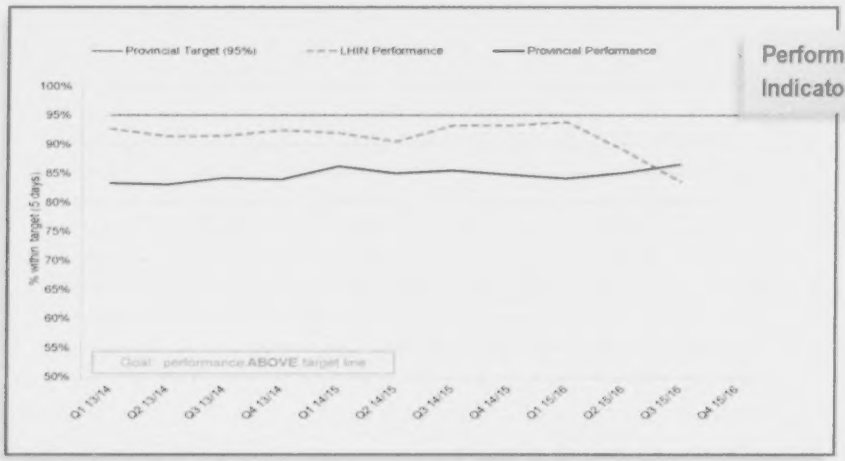
Performance Indicator #14

Home and Community Care

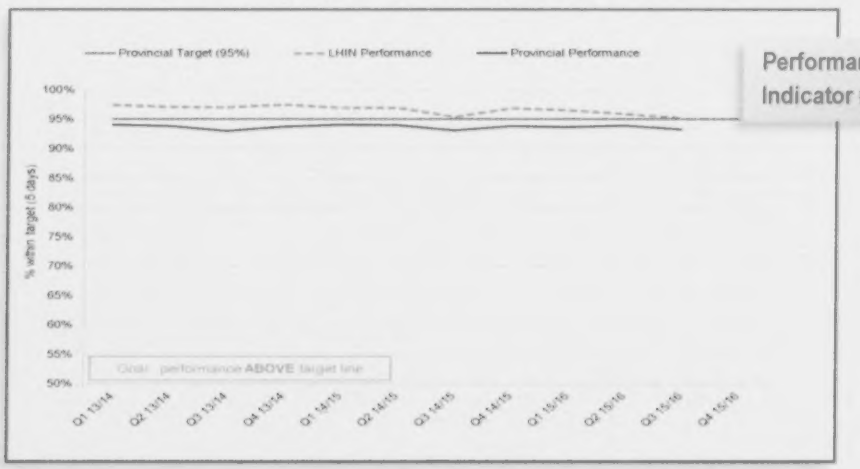
To prevent or delay visits to EDs, hospitalizations, and applications to Long Term Care (LTC), and to enable discharge from hospital, Community Care Access Centres (CCAC's) provide a variety of in-home support services in addition to assisting local residents navigate a host of additional community services. LHINs are measured on the

time it takes for a resident to receive CCAC support services, after having applied for the service. This period includes both the time from application to assessment and from assessment to delivery of services.

Performance Indicator #1: Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services Services provided in the home prevent or delay emergency department visits and hospitalizations. The provincial access target for the time between when clients are authorized for personal support and the time that they begin receiving that support is five days. At a system level, we measure what proportion of the clients receiving services are receiving them within that provincial target. In calendar year 2015, the Central West LHIN ranked 6th out of 14 LHINs for this indicator, with 88% of clients receiving their personal support visit within 5 days.

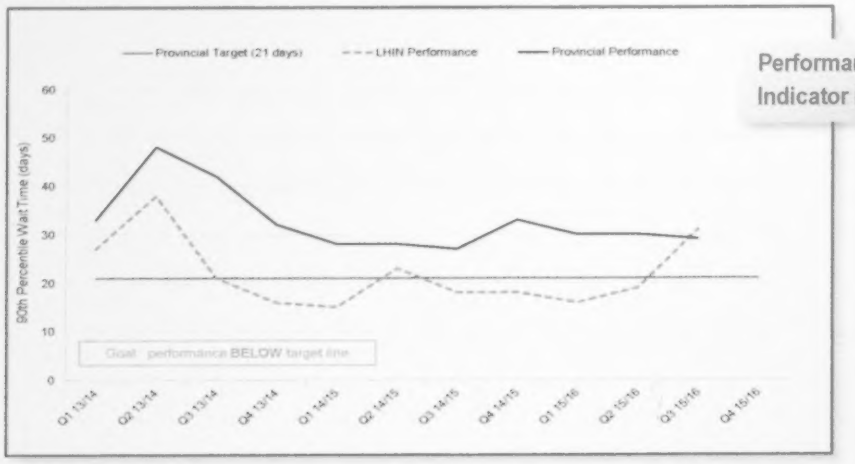


Performance Indicator #2: Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services | Services provided in the home prevent or delay ED visits and hospitalizations. The provincial access target for the time between when clients are authorized for nursing services and the time that they begin receiving that support is five days. At a system level, we measure what proportion of the clients receiving services are receiving them within that provincial target. At 95%, the Central West LHIN was the only LHIN meeting the provincial target in this indicator during calendar year 2015.



Performance Indicator #3: 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) | The longer a client who needs in-home services at home waits to receive it, the more likely it is that that client's condition will deteriorate, and that they will require a visit to the emergency department and potential hospitalization. The provincial access target for the time between when clients are authorized for in-home services and the time that they begin receiving that support is 21 days.

The Central West LHIN met this target during calendar year 2015, ranking 5th out of 14 LHINs. An increase in wait time in the third quarter is reflective of an influx of funding into the system which allowed a larger number of people to be removed from the waitlist.

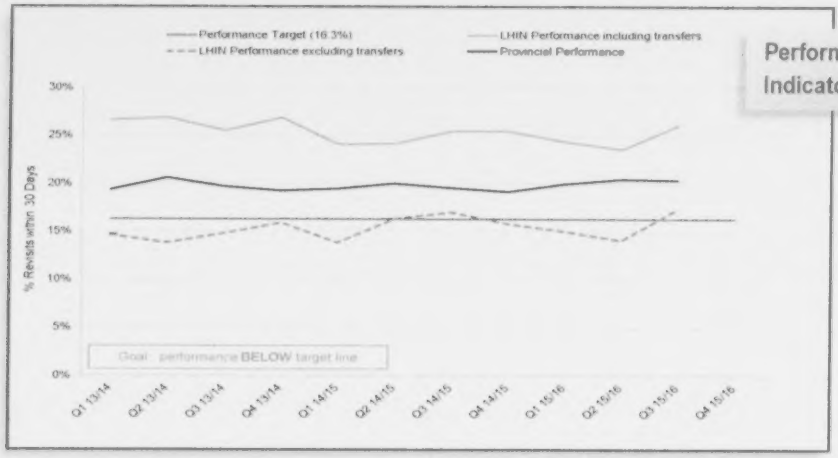


Health and Wellness of Ontarians... Mental Health

Visits to hospital EDs may be the appropriate point of access to care for individuals with mental health and substance abuse conditions who are in crisis. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care and can contribute to emergency visit pressures.

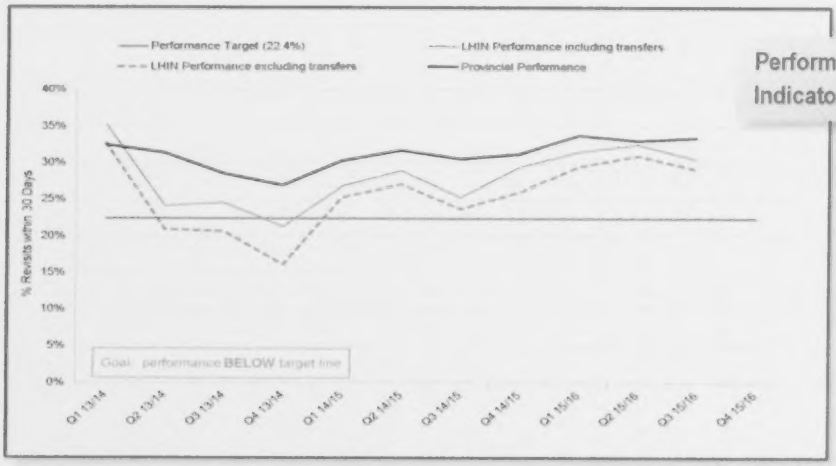
Given the chronic nature of the mental health and substance abuse conditions, access to effective community services should reduce the number of repeat unscheduled emergency visits for Ontario residents. This measure attempts indirectly to measure the availability and quality of community services for patients with mental health and substance abuse conditions. It also supports the future development and improvement of data collected that could be used to measure the quality and availability of community mental health and substance abuse services directly, especially relating to wait times.

Performance Indicator #12: Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions | Within this calculation, the MOHLTC considers a repeat visit" to have occurred every time a patient is transferred from one ED to another. This despite the fact that these transfers took place within the same "episode of care", with no opportunity for the patient to receive community services between the two departments. In-depth analysis at the Central West LHIN level suggests that when these types of transfers are excluded from the measurement, actual performance is much better than what is purported by the provincial calculation. More Central West LHIN residents are receiving the care they need in the community to prevent repeat visits to EDs.



Performance Indicator #12

Performance Indicator #13: Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions | LHIN analysis shows that patients with substance abuse conditions are also receiving better services than is suggested by provincial reporting. However, the difference is not as pronounced as it is for patients with mental health conditions. During the performance period (January-December 2015) alcohol accounted for more than 80% percent of repeat visits for substance abuse, and fewer than 30 patients accounted for more than 50% of the repeat visits.



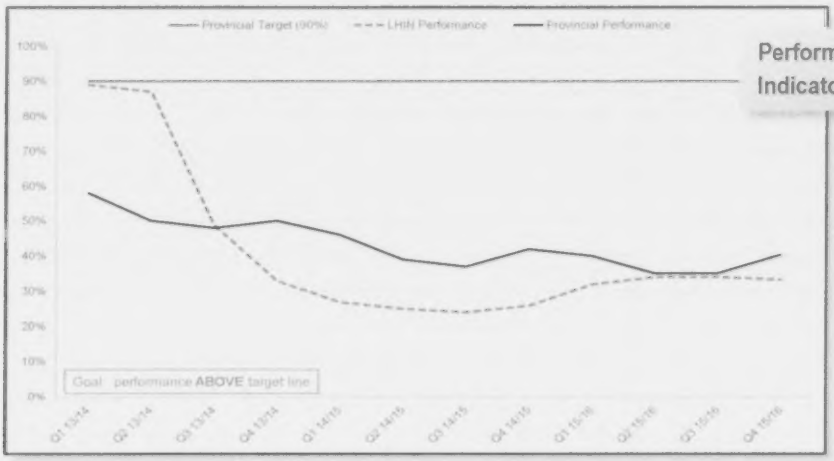
Performance Indicator #13

Wait Times

Wait time indicators measure the proportion of patients who received their surgical or diagnostic imaging procedures within established provincial access targets. Patients waiting for these procedures are placed, by their physician, into one of four categories according to how quickly they need the procedures. LHIN performance is measured for patients in the all but the most urgent category; Priority I patients are expected to receive services immediately.

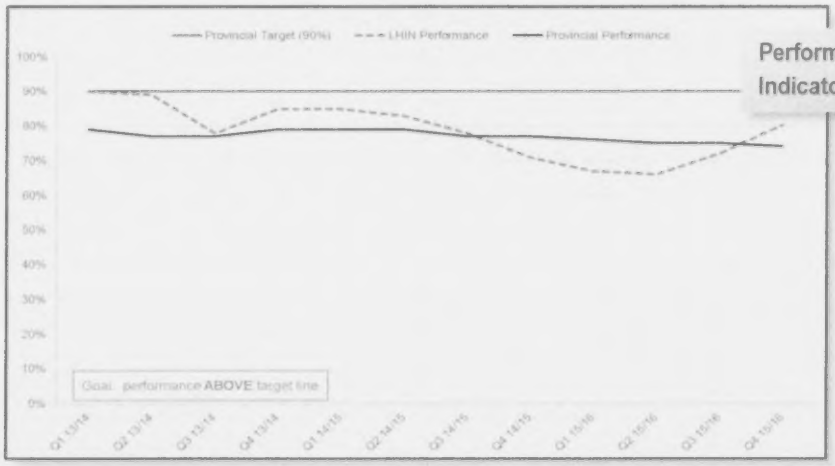
Diagnostic Imaging

Performance Indicator #6: Percent of priority 2, 3 and 4 cases completed within access target for magnetic resonance imaging (MRI) scans| In 2015/16, the Central West LHIN ranked 10th out of 14 LHINs in this indicator, with 33% of patients receiving a diagnostic MRI within the provincial access targets, 5 percentage points lower than the province as a whole. The LHIN has neither the physical nor the financial capacity to meet the local demand for MRI scans.



Performance Indicator #6

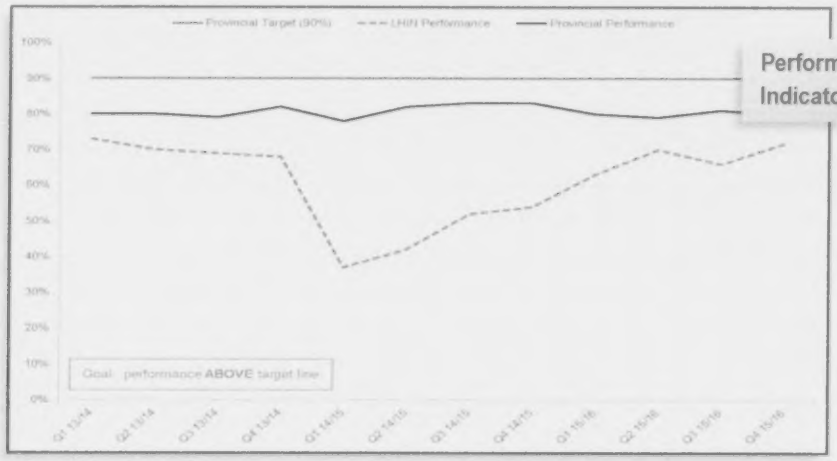
Performance Indicator #7: Percent of priority 2, 3 and 4 cases completed within access target for computerized tomography (CT) scans | In 2015/16, the Central West LHIN ranked 9th out of 14 LHINs for this indicator, with 72% of patients receiving a diagnostic CT within the provincial access targets, 4 percentage points lower than the province as a whole.



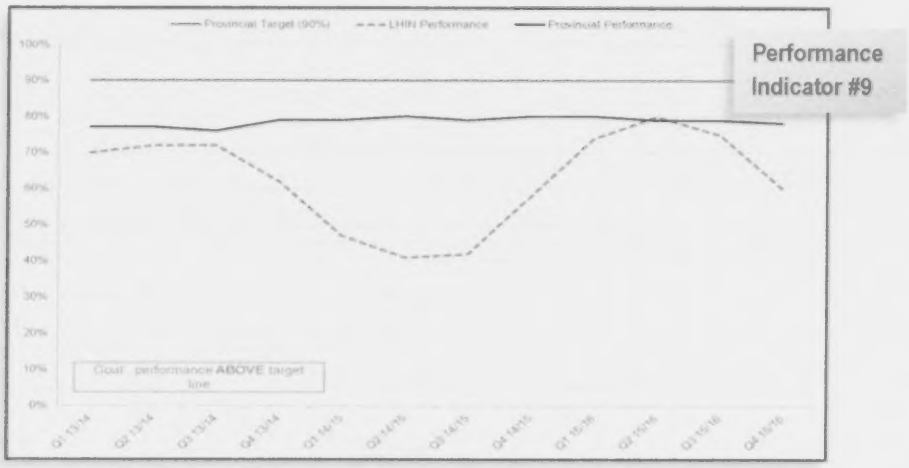
Performance Indicator #7

Surgical Procedures

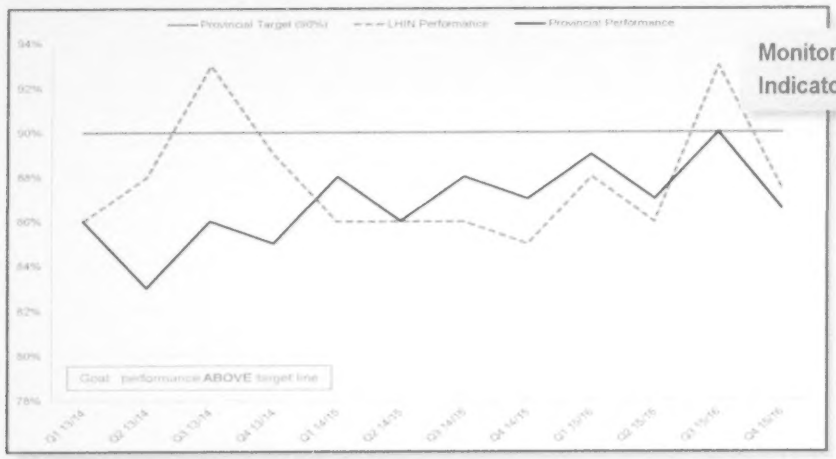
Performance Indicator #8: Percent of priority 2, 3 and 4 cases completed within access target for hip replacement | While demand for joint replacement elective surgeries continues to outstrip funded supply, Central West LHIN hospitals completed all surgeries for which the MOHLTC allocated funding for in 2013/14. These numbers were not sufficient to clear the wait list.



Performance Indicator #9: Percent of priority 2, 3 and 4 cases completed within access target for knee replacement | As with hip replacement surgeries, the demand for knee replacement elective surgeries exceeds the supply currently funded by the Ministry of Health and Long-Term Care.



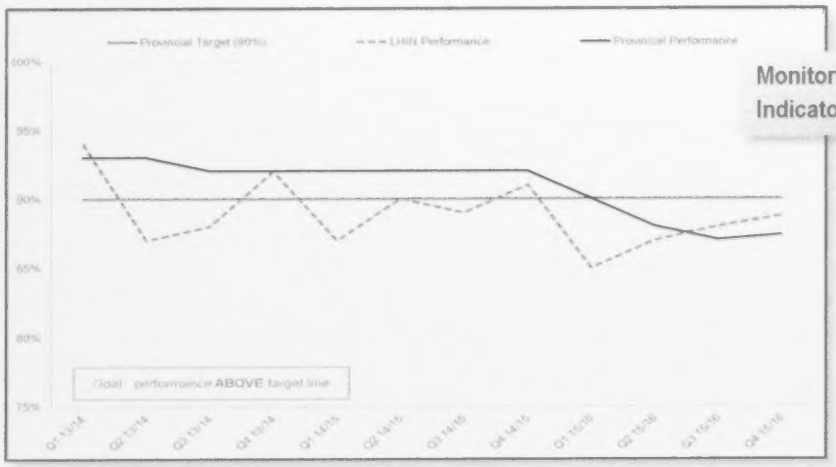
Monitoring Indicator #15: Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery | The Central West LHIN missed the provincial target of 90% by only one percentage point in 2015/16.



Monitoring Indicator #16: Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery | No hospitals within the Central West LHIN provide cardiac by-pass procedures.

**There is no chart for this monitoring indicator.

Monitoring Indicator #17: Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery | The Central West LHIN missed the provincial target of 90% by only three percentage points in 2015/16, and completed all funded procedures.

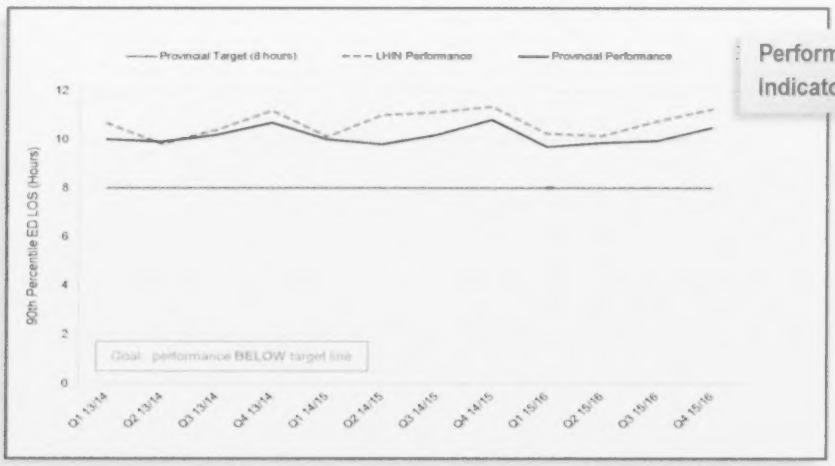


Emergency Department (ED) Length of Stay

Emergency department (ED) indicators measure the length of time from patient arrival at the ED, to patient discharge from the ED. This measure includes wait time as well as diagnosis, treatment and monitoring time.

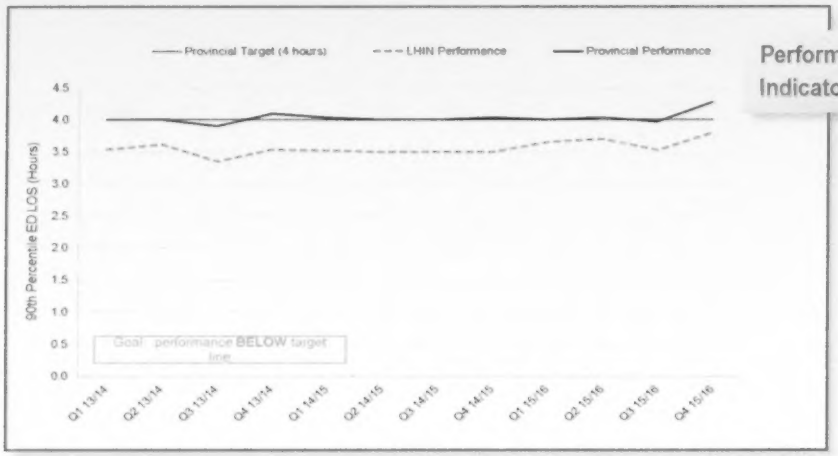
Performance Indicator #4: 90th percentile emergency department (ED) length of stay for complex patients | Most patients who are triaged as high acuity or who require admission to an inpatient bed benefit from up to 8 hours in the emergency department. This time is spent being assessed, treated, and stabilized, and allows the physicians at the hospital to make a decision about whether the patient can be discharged home or needs to be admitted to an inpatient unit. After 8 hours, it is more likely that additional time spent in the emergency department does not add value to the patient's care, and that if they have not already been discharged home, they would be better off with the longer-term and more specialized care associated with an inpatient unit.

Central West LHIN performance in 2015/16 missed the provincial target by just under three hours—this performance is entirely due to the wait time experienced by patients waiting in the ED for admission to an inpatient unit. The Central West LHIN has the highest proportion of high acuity ED visits of any LHIN, and the lowest admission rate for high acuity patients. It also has the lowest ALC rate of any LHIN. However, Brampton Civic Hospital (BCH) consistently experiences both the highest overall volume of any ED in Canada, leading to a greater need for acute hospital capacity than exists in the LHIN. Fluctuations in performance indicate the LHIN's response to and management of these volumes.



Performance Indicator #4

Performance Indicator #5: 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients | Most patients who are triaged as having a minor or uncomplicated problem benefit from up to 4 hours in the emergency department. This time is spent being assessed, treated, and stabilized. After 4 hours, it is more likely that additional time spent in the emergency department does not add value to the patient's care, and that at least some of the time spent in the ED has been spent waiting. In 2015/16, Central West LHIN length of stay for low acuity patients was third best in the province, well within the 4-hour provincial target.



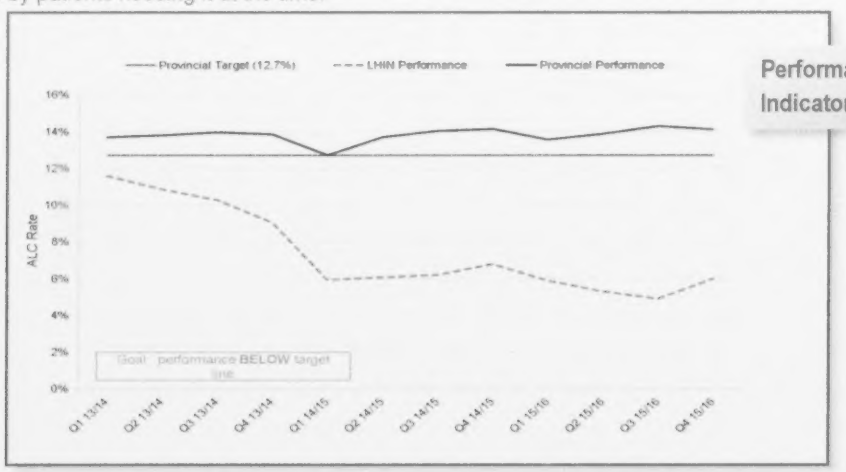
Performance Indicator #5

Alternate Level of Care

When a hospital inpatient has completed her hospital stay, she should be discharged to the next most appropriate destination for her condition. Alternate Level of Care (ALC) refers to those patients who continue to occupy hospital beds after they have completed a course of treatment for which they were admitted and no longer require the care associated with those beds. For a variety of reasons, these patients experience barriers to discharge from hospital. The patient could be waiting for a lower level of care within a hospital, or for a lower level of care in the community or long term care.

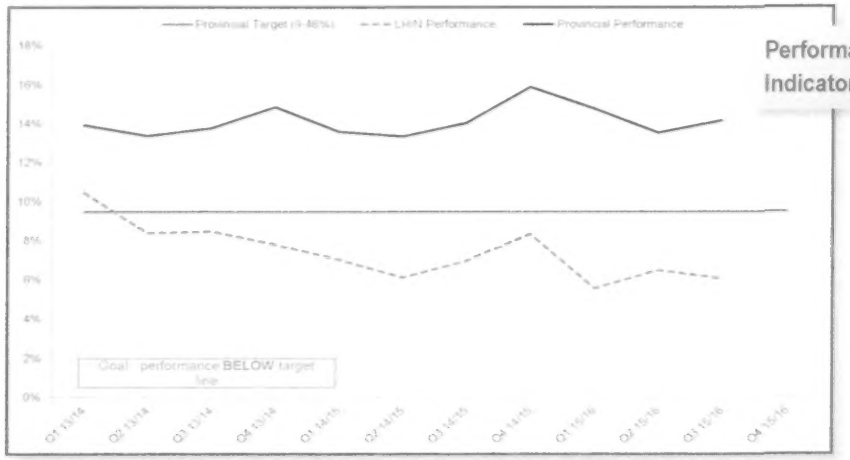
Performance Indicator #11: ALC rate | Every hospital bed occupied by a patient designated ALC is a bed that is no longer included in the overall hospital's capacity. A patient who is designated ALC is occupying a hospital bed that, in many cases, is needed by a patient waiting in a different part of the system, such as the emergency department. Additionally, a day in a higher level of care costs the system more than a day in a lower level of care. A reduction in ALC days results in more beds being available for those who need in-hospital treatment and makes better use of health system resources.

In 2015/16, the Central West LHIN had the lowest (best) ALC rate in the province, keeping the majority of inpatient capacity in use by patients needing it at the time.



Performance Indicator #11

Performance Indicator #10: Percentage of Alternate Level of Care (ALC) Days | All ALC days are non-value added for the patient; they are pure wait time, during which by definition the patient is not receiving the care they need. In addition, a patient who is designated ALC is in a riskier environment than necessary (potentially exposed to hospital-acquired infections, not being activated and socialized). Patients remain in hospital longer than necessary for various reasons, including room availability in residential facilities, delay's in discharge, and social and familial situations. The Central West LHIN had the best performance of all 14 LHINs during the calendar year 2015, meaning that patients who were discharged from Central West LHIN hospitals spent less time waiting for care in their homes, in Long-Term Care or in post-acute beds. In 2015/16, the LHIN was one of only two LHINs to meet the provincial target for this indicator.

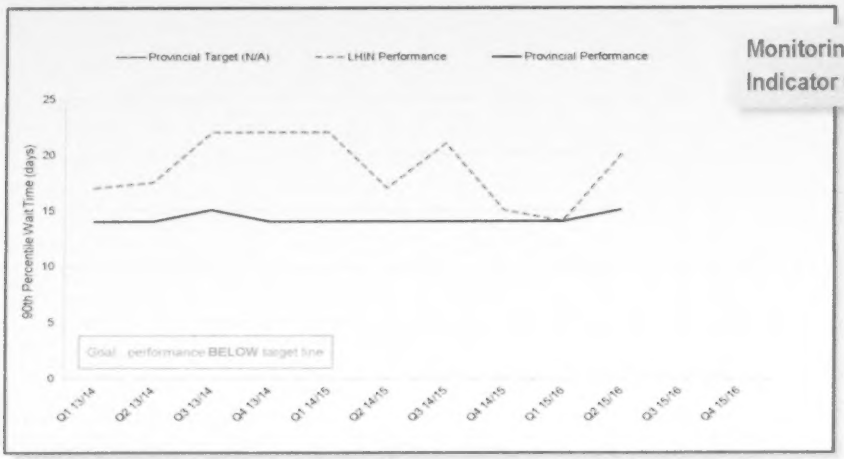


Performance Indicator #10

Long Term Care

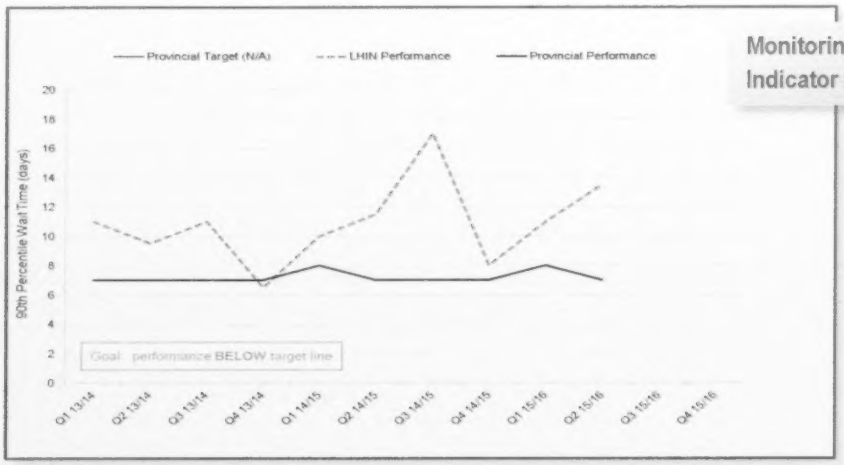
These measures are indications of the Central West LHIN resident's experience—how long did it take for residents to be evaluated for eligibility for care in a Long-Term Care Home (LTCH). 100% of the time measured for this metric is wait time, and therefore non-value added. The CCAC determines a person's eligibility for admission to an LTCH based on parameters and requirements outlined by the MOHLTC. There are no performance targets for these measures.

Monitoring Indicator #18(a): CCAC wait times from application to eligibility determination for long-term care home placements: from community setting | Nine out of ten Central West LHIN residents awaiting assessment in their homes waited up to 16 days for this assessment between October 2014 and September 2015. The Central West LHIN ranked 8th out of 14 LHINs in this measure.



Monitoring Indicator #18a

Monitoring Indicator #18(b): .CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting | Nine out of ten Central West LHIN residents awaiting assessment in hospital waited up to 12 days for this assessment between October 2014 and September 2015. The Central West LHIN ranked 12th out of 14 LHINs in this measure



Monitoring Indicator #18b

ENGAGING LHIN COMMUNITIES

The Local Health System Integration Act (LHSIA) is based, in part, on a belief that the health care needs of local communities are best understood by those who live and work in them. It follows that the ability to understand the needs of local Central West LHIN communities is predicated on developing meaningful relationships, in large part through effective community engagement.

Community engagement itself, is as much about helping LHIN residents to better understand their local health care system, as it is about listening to their perceptions and needs, empowering them to be active participants in the planning process.

In 2015/16 the Central West LHIN conducted communications and community engagement activities with the following objectives in mind:

Business Objectives

- Improve access to care
- Streamline transitions and navigation of the system
- Drive quality and value
- Build on the momentum

Communication Objectives

- Educate and build broad stakeholder awareness of Central West LHIN strategic imperatives and priorities identified in IHSP 3 (above noted business objectives).
- Foster an understanding of the need for continued health system transformation.
- Build ongoing support for an integrated sustainable local health care system that places the needs of patients first, and patients themselves at the centre of their local health care system.

- Raise awareness of the Central West LHIN's role, its unique characteristics, value proposition, caliber and credibility of work, and importance within the local health care system.
- Educate and build awareness among HSPs regarding shared accountability for local health system transformation and the alignment of their respective/initiatives with IHSP 3.
- Continue to build strong, trusted relationships with HSP communications teams across the Central West LHIN, working together to optimize communication resources and coordinated services.

Throughout 2105/16 the Central West LHIN continued to place an emphasis on the strong, meaningful relationships it has developed with residents, HSPs, community partners and those agencies not funded by the LHIN but whose activities contribute to the overall design and integration of their local health care system. The Central West LHIN executed its communications and community engagement activities through use of a variety of tools/tactics including:

News Releases	As required, to highlight and/or promote Central West LHIN activities/events.
eNewsletter – "Working Together for Healthy Change"	Monthly electronic periodicals providing updates on local LHIN activities, issued to a broad, general stakeholder audience.
Mid-year Community Update	Year-to-date progress report to the community, highlighting progress made in regard to IHSP and ABP deliverables.
MPP Meetings	Quarterly face-to-face updates and information sharing sessions.
Governance and Senior Leadership Forum	Three sessions held in 2015/16 - Two re: IHSP 2016/19 - Patients First Discussion Paper
Regional, Municipal, Civic Council Meetings	Contingent on schedule availability.
Annual Business Plan	Published annually.
Annual Report	Published annually for the year previous.
Board Materials	Posted to Central West LHIN Website ahead of and following monthly Board meetings.

Patients First Discussion Paper... join the conversation

In December 2015, the MOHLTC released a discussion paper entitled Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario. The discussion paper outlined four key proposals including:

- More effective integration of services and greater equity
- Timely access to primary care, and seamless links between primary care and other services
- More consistent and accessible home and community care
- Stronger links between population and public health and other health service.

With release of the discussion paper, the Ministry asked Ontario's LHINs to assist with stakeholder engagement, obtaining input regarding the proposals contained within, and advice about how to further integrate improvements across the health care system.

The Central West LHIN conducted a series of face-to-face engagement sessions with a variety of stakeholders. The LHINs approach was to conduct public engagement session in each of the Central West LHIN's five sub-geographic areas, while also conducting targeted stakeholder consultations with Aboriginal and Francophone communities, the Central West LHIN Primary Care Network, and Governors and leaders from HSPs across the LHIN.

Over 300 residents and health care professionals joined in the conversation to be active participants in shaping the future of their local health care system, their ideas being compiled and submitted to the Ministry in a comprehensive report of findings.

How are we doing?... resident and HSP satisfaction

In developing IHSP 2016-2019, the LHIN conducted a random sample telephone poll to gather opinions from a representative sample of residents regarding their knowledge, attitudes, and opinions of the local health care system. It was the fourth such study, building on similar research conducted in 2006, 2009 and 2013. It also served to validate the priorities and directions highlighted in IHSP 2016-2019.

Of note, LHIN residents remain concerned about wait times, as well as the impact of chronic diseases and an aging population. Of those residents who said that the Central West LHIN is moving in the right direction, the most common reasons for this response was that health care/services have improved. Among those who say health care/services have improved, it is largely attributed to improved access and efficiencies. The highest rated health care service within the LHIN is primary care. And, LHIN residents hold high expectations of health care services, with nearly all residents saying they agree with the statement... "*the health care system should strive to provide health care in the home and community, not just in hospitals.*"

The Central West LHIN also conducted a third survey of regional Health Service Providers in 2015/16. Once again, the survey was designed to better understand the relationship between LHIN and local HSPs, as well as how providers feel the region as a whole has moved forward on local health system priorities.

Survey results were very positive and largely comparable to those obtained in 2014. Health system funding and planning, along with community engagement are the top three LHIN activities HSPs placed the most importance on. The LHIN has and continues to build very strong relationships with HSPs in the region. Consistent with the 2014 survey, quantitative results demonstrated no areas where respondents felt primarily negative about the LHIN or its efforts. HSPs are aware of, and understand, the broader health system challenges faced by the LHIN and, while they are of concern for HSPs they see the LHIN as a partner in addressing those concerns.

The Road Ahead

Planning for and realizing the future need of Central West LHIN residents and communities.

Capital Investment

Following a number of infrastructure announcements in 2013 and 2014, 2015 saw the advancement and physical development of a number of important projects, all of which are being designed with the needs of LHIN residents and patients at their centre.

• Etobicoke General Hospital

William Osler Health System's Etobicoke General Hospital (EGH) site reached another important milestone in its redevelopment journey. In November, Osler and Infrastructure Ontario (IO) announced that the Request for Proposals phase of the project had been closed after a six-month period. At the writing of this report Osler and IO have since awarded a fixed price contract to Etobicoke Healthcare Partnership (EHP) to design, build, finance and maintain a new four-storey wing at Etobicoke General Hospital.

Construction of the new wing is expected to be completed in late 2018. Upon completion, the wing will add approximately 250,000 square feet of space to the hospital and house the services most urgently needed by the community it serves including...

- a larger, state-of-the-art emergency department
- Cardiac Care and Intensive Care Units
- a Maternal newborn unit with birthing suites and a specialized nursery
- a new ambulatory procedures unit
- Cardiorespiratory and neurodiagnostic services.

Osler is also planning for the construction of a new ancillary building on the EGH Site. Expected to begin in May 2016, this building will house a number of outpatient programs and services, including a fracture clinic, diagnostic imaging, and a satellite dialysis program.

▪ Peel Memorial Centre for Integrated Health and Wellness

The summer of 2015 saw the "topping off" of the new Peel Memorial Centre for Integrated Health and construction on this wonderful new facility is progressing steadily.

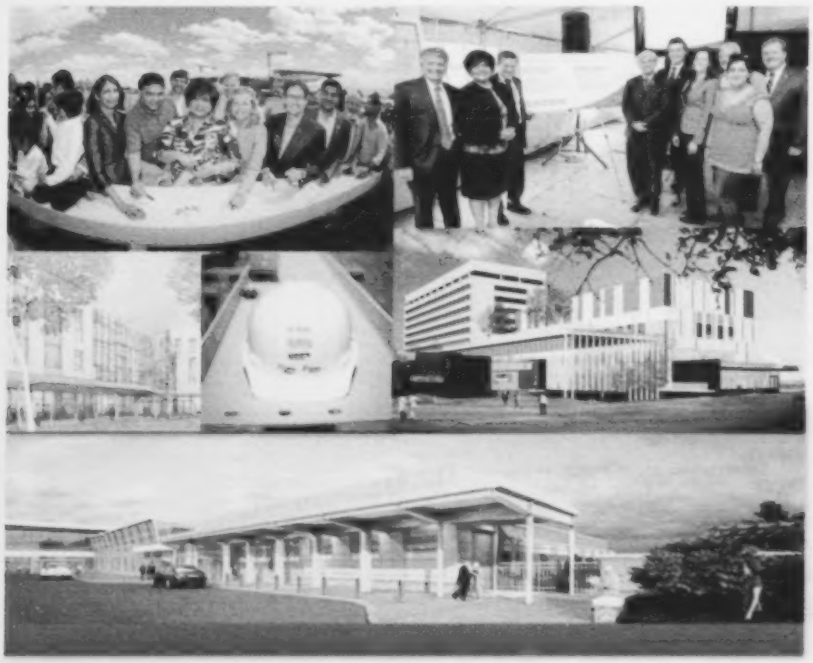
With completion of the exterior brickwork and penthouse siding, much of the construction activity moved inside the building, and the signature multi-coloured glass wall in the main lobby is in place, ready to greet patients and visitors as they enter the building.

Slated for completion in early 2017, Peel Memorial is a new, state-of-the-art hospital that will provide complimentary services to Brampton Civic Hospital, offering a range of specialty clinics, day programs and services – from high-tech diagnostics and surgery, to women's and children's health. Space has also been allocated for education classrooms where patients and family members will be able to learn from health care professionals about how to take a more active role in managing their own health.

▪ Headwaters Health Care Centre

Throughout 2015/16, Headwaters Health Care Centre (HHCC) continued to prepare for its expansion and renovation project, a significant step forward in increasing access to important health care services for the growing community.

Addition of the new space is the first major expansion of the hospital since it opened at its current location in 1997. A new, 8,200 square foot extension will be home to much-needed clinics, services and programs like chemotherapy, minor procedures, orthopaedics and telemedicine. HHCC is also taking on an exciting renovation of existing hospital space to add another operating room, improve reception and expand pre- and post-surgical recovery areas.



▪ "Building" Healthy Communities

Not only have capital projects progressed at Central West LHIN hospitals, so too have they moved forward across LHIN communities.

- **WellFort Community Health Centre** | Expansion is taking place at the Malton satellite to accommodate additional programming including primary care, youth services, oral healthcare, health promotion programs, physiotherapy, and chiropody and diabetes education.

- **Rexdale Community Health Centre** | The Jamestown satellite project will provide much needs services to the local community including primary care, dental services, and diabetes education.

- **Rexdale Community Health Centre** |The Kipling Dixon proposal will result in improvements to this existing location, expanding square footage to improve and enhance program service delivery.

- **Kipling Acres** | Redevelopment of Kipling Acres continues following the opening of Phase 1 in March 2014, representing an initial 192 bed home. Phase 2, currently under construction an additional 145 beds, is expend to open in 2016.

▪ Healthy Communities Initiative

Building healthy communities is more than bricks and mortar. Like many communities around the globe and across Canada, Brampton is addressing a common need, ensuring children, youth, adults and families are engaged in active healthy living so as to reduce their risk of health concerns and chronic illness.

In 2015 the Central West LHIN was proud to take a leadership role in the development of the Healthy Communities Initiative, bringing together community leaders and partners to explore ways in which to create an active, healthy community, and to develop a plan for getting more **PEOPLE**, more **ACTIVE**, more **OFTEN**... mentally, physically and spiritually. The Central West LHIN will continue to take a leadership role in this initiative moving forward in 2016/17.

■ Patients First and IHSP 2016-2019

In 2015/16, there was perhaps no greater example of planning for the future than with the release of Ontario's Patients First: Action Plan for Health Care and the subsequent planning and development of the LHIN's new Integrated Health Service Plan... IHSP 2016-2019.

▪ Ontario's *Patients First*: Action Plan for Health Care

Released by the Minister of Health and Long-Term Care (MOHLTC) in February 2015, Ontario's *Patients First*: Action Plan for Health Care builds on a strong foundation set by Ontario's original Action Plan for Health Care in 2012, and strengthens the government's commitment to put patients first by improving their health care experience.

While the 2012 Action Plan led to a number of important successes, it has been recognized that there still exists much work to be done to improve the patient experience, make the health care system more transparent and accountable, and to ensure the universal health care system will be there when needed for generations to come.

Ontario's *Patients First:* Action Plan for Health Care recognizes the economic and demographic realities of finite financial resources and a growing and aging population. It also recognizes the need to approach such realities from a different perspective, where we ask how we can ensure universality, improve access, and deliver the highest quality of care to people. The answer is a matter of choice... choice rooted in evidence-based practices; patient experiences; a commitment to equity, access and universality; and decision making where patients come first.

The development of IHSP 2016-2019was guided by Ontario's *Patients First:* Action Plan for Health Care. Although the LHIN is not accountable for all of the initiatives identified in *Patients First,* local priorities and initiatives outlined in IHSP 2016-2019 align with the objectives contained in the plan.

- **IHSP 2016-2019**

IHSP 2016-2019 is the Central West LHIN's fourth strategic plan. It defines the LHIN's mission, vision, values and strategic priorities, outlining how it will go about achieving them. Building on the momentum of its earlier IHSPs it outlines how together, with HSPs and community partners, the LHIN intends to plan, integrate, fund and monitor the local health care system. These efforts are discussed in terms of the LHIN's Strategic Directions, Initiatives and Actions.

Ambitious yet actionable, and flexible in its ability to adapt to the changing needs of the health care environment, IHSP 2016-2019 is rooted in the common vision and priorities of Ontario's Patients First: Action Plan for Health Care, and common objectives of Ontario's 14 LHINs. It has also been developed based on an environmental scan of the LHIN, input from community members, client groups and local Health Service Providers (HSPs), and with guidance from the Central West LHIN Board of Directors and staff.

Working together, these Directions, Initiatives and Actions establish a comprehensive, focused and disciplined approach toward the attainment of desired outcomes, and reaffirm the Central West LHIN's commitment to put people and patients at the centre of their local health care system... to improve their health care outcomes and experiences.

To advance the priorities outlined in IHSP 2016-2019, the Central West LHIN will continue to focus on partnerships among patients, caregivers, providers, cross-sector partners and the community at large. The LHIN will also monitor and report on its progress to the Ministry of Health and Long-Term Care (MOHLTC), and broader community. Through a variety of reports that include the Central West LHIN's Annual Business Plans (ABPs) and Annual Reports (ARs), local residents, patients and providers will have access to up-to-date information about the performance of their local health care system, and how well the LHIN is progressing with its Strategic Directions.

The Central West LHIN has been a significant driver of healthy change since 2006. Gains that have been achieved, and those it plans to achieve in the future, are based on hard work by HSPs, community partners and the LHIN over the past decade.

While the local health care system is further ahead today, much work remains to be done – particularly in achieving a genuinely integrated health system. IHSP 2016-2019 provides the Central West LHIN with the foundation necessary to meet new challenges and to take a leadership role in the advancement of high-quality, patient-centred health care across Ontario.

Both residents and health care professionals alike place high value on their health care system, and the need for it to be responsive to local communities. Accordingly, putting patients first will remain a shared responsibility as we move forward **Together**... **Making** Healthy **Change Happen!**

BUILD INTEGRATED NETWORKS OF CARE
- Health Links & Primary Care
- Home and Community Care Renewal
- Mental Health & Addictions Services
- Palliative and End-of-Life Care
- Long-Term Care Renewal
DRIVE QUALITY & VALUE
- Improve the Patient Experience
- Quality and Innovation
- Health System Funding Reform
- Enabling Technology Integration
Healthy Change
DEMONSTRATE SYSTEM LEADERSHIP
- System Capacity Planning
- Population Health
- Dementia Strategy
- Build on the Momentum
CONNECT & INFORM
- Community Engagement
- French Language Services
- Aboriginal Health

Financial statements of

Central West Local Health Integration Network

March 31, 2016

Central West Local Health Integration Network

March 31, 2016

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Independent Auditor's Report

To the Members of the Board of Directors of the
Central West Local Health Integration Network

We have audited the accompanying financial statements of Central West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2016, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Central West Local Health Integration network as at March 31, 2016 and the results of its operations, changes in its net debt, and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 25, 2016

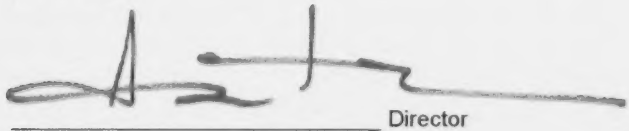
Central West Local Health Integration Network

Statement of financial position
as at March 31, 2016

	2016	2015
	$	$
Financial assets		
Cash	**1,251,774**	706,145
Accounts receivable		
Ministry of Health and Long-Term Care ("MOHLTC") - Health Service Providers ("HSP")	**439,533**	6,781,259
Due from other LHINs - Enabling Technologies for Integration (Note 3b)	**8,666**	89,518
Due from LHIN Shared Services Office (Note 4)	**31,237**	-
Other	**105,905**	78,356
	1,837,115	7,655,278
Liabilities		
Accounts payable and accrued liabilities	**770,676**	671,920
Due to MOHLTC (Note 3c)	**624,171**	214,830
Due to HSP	**439,533**	6,781,259
Due to the LHIN Shared Services Office (Note 4)	**-**	1,426
Due to other LHIN	**11,339**	-
Deferred capital contributions (Note 5)	**17,012**	38,348
	1,862,731	7,707,783
Net debt	**(25,616)**	(52,505)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**8,604**	14,157
Tangible capital assets (Note 7)	**17,012**	38,348
	25,616	52,505
Accumulated surplus	**-**	-

Approved by the Board

Director
(Maria Britto)



Director
(Adrian Bita)

The accompanying notes to the financial statements are an integral part of these financial statements.

Central West Local Health Integration Network

Statement of operations
year ended March 31, 2016

	Budget (Note 8)	2016 Actual	2015 Actual
	$	$	$
Revenue			
MOHLTC funding			
Health Service Provider ("HSP") transfer payments (Note 9)	**857,175,523**	**883,716,367**	870,843,813
Operations of LHIN	**4,181,828**	**4,141,827**	4,130,791
Project Initiatives			
Enabling Technologies for Integration Project Management Office	-	**3,060,000**	3,060,000
French Language Services	**106,000**	**106,000**	106,000
ER/ALC Performance Lead	**100,000**	**100,000**	100,000
Emergency Department Lead	-	**75,000**	72,766
Aboriginal Health	**7,500**	**7,500**	7,500
Primary Care Lead	-	**75,000**	73,031
Critical Care Lead	-	**75,000**	72,750
Diabetes Regional Coordination	**839,175**	**839,175**	781,301
Physiotherapy Planning Funds	-	-	-
Amortization of deferred capital contributions (Note 5)	-	**21,336**	73,598
	862,410,026	**892,217,205**	879,321,550
eHealth-Enabling Technologies for Integration allocated to LHIN's (Note 3b)	-	**(1,877,630)**	(2,189,367)
Funding repayable to the MOHLTC (Note 3a)	-	**(409,341)**	(214,830)
	862,410,026	**889,930,234**	876,917,353
Expenses			
Transfer payments to HSPs (Note 9)	**857,175,523**	**883,716,367**	870,843,813
General and administrative (Note 11)	**4,181,828**	**4,128,891**	4,157,711
Project Initiative (Note 10)			
Enabling Technologies for Integration Project Management Office	-	**912,074**	759,535
French Language Services	**106,000**	**106,000**	104,870
ER/ALC Performance Lead	**100,000**	**100,000**	100,000
Emergency Department Lead	-	**72,000**	72,016
Aboriginal Health	**7,500**	**5,278**	6,610
Primary Care Lead	-	**69,769**	72,281
Critical Care Lead	-	**72,000**	72,000
Diabetes Regional Coordination	**839,175**	**747,855**	728,517
	862,410,026	**889,930,234**	876,917,353
Annual surplus	-	-	-
Accumulated surplus, beginning of year	-	-	-
Accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

Central West Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2016

	2016	2015
	$	$
Annual surplus	-	-
Acquisition of tangible capital assets	-	(51,037)
Amortization of tangible capital assets	**21,336**	73,598
Change in other non-financial assets	**5,553**	30,986
Decrease in net debt	**26,889**	53,547
Net debt, beginning of year	**(52,505)**	(106,052)
Net debt, end of year	**(25,616)**	(52,505)

The accompanying notes to the financial statements are an integral part of these financial statements.

Central West Local Health Integration Network

Statement of cash flows
year ended March 31, 2016

	2016	2015
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**(21,335)**	(73,598)
Amortization of deferred capital contributions (Note 5)	**21,335**	73,598
Changes in non-cash operating items		
Accounts receivable - MOHLTC	**6,341,726**	(3,974,063)
Due to the MOHLTC	**409,341**	(197,616)
Due to HSP's	**(6,341,726)**	3,974,063
Due from other LHINs	**80,852**	140,896
Due from LHIN Shared Services Office	**(31,237)**	-
Accounts receivable - other	**(27,549)**	10,671
Prepaid expenses	**5,553**	30,986
Accounts payable and accrued liabilities	**98,756**	175,383
Due to Other LHIN	**11,339**	-
Due to the LHIN Shared Services Office	**(1,426)**	468
	545,629	160,788
Capital transaction		
Acquisition of capital assets	-	51,037
Financing transaction		
Deferred capital contributions (Note 5)	-	(51,037)
Net increase (decrease)in cash	**545,629**	160,788
Cash, beginning of year	**706,145**	545,357
Cash, end of year	**1,251,774**	706,145

The accompanying notes to the financial statements are an integral part of these financial statements.

1. Description of business

The Central West Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Central West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers Dufferin County, the northern portion of Peel Region, part of York Region, and a small part of the City of Toronto. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Services Providers ("HSP"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2016.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Funding payments to HSPs in the LHIN geographic area flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2016.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

2. Significant accounting policies (continued)

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

3. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA and TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2016 Excess funding	2015 Excess funding
	$	$	$	$
Transfer Payments to HSP's	883,716,367	883,716,367	-	-
LHIN Operations (Note 11)	4,163,163	4,128,891	34,272	46,678
Capital contribution (Note 11)	-	-	-	-
eHealth - Enabling Technologies for Integration (Note 10)	3,060,000	2,789,704	270,296	111,098
French Language Services (Note 10)	106,000	106,000	-	1,130
ER/ALC Performance Lead (Note 10)	100,000	100,000	-	-
Emergency Department Lead (Note 10)	75,000	72,000	3,000	750
Aboriginal Health (Note 10)	7,500	5,278	2,222	890
Primary Care Lead (Note 10)	75,000	69,769	5,231	750
Critical Care Lead (Note 10)	75,000	72,000	3,000	750
Diabetes Regional Co-ordination (Note 10)	839,175	747,855	91,320	52,784
	892,217,205	891,807,864	409,341	214,830

b) Enabling Technologies for Integration Project Management Office

Effective April 1, 2013, the LHIN entered into an agreement with Central, Central West, Central East, Toronto Central, Mississauga Halton and North Simcoe Muskoka (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The Central West LHIN is designated the Lead LHIN within this agreement and as such holds the accountability over the distribution of the funds and manages the shared Project Management Office. In the event that the Cluster experiences a surplus the Lead LHIN is responsible for returning those funds to the MOHLTC. The total Cluster funding received for the year ended March 31, 2016 was $3,060,000 (2015 - $3,060,000).

Funding of $1,886,296 (2015 - $2,278,885) was allocated to other LHIN's within the cluster who incurred eligible expenses of $1,877,630 (2015 - $2,189,367). A summary of eHealth Enabling Technologies for Integration Funding and expenses for the cluster are as follows:

3. Funding repayable to the MOHLTC and eHealth Ontario (continued)

b) Enabling Technologies for Integration Project Management Office (continued)

The surplus from other LHINs is as follows:

	Funding allocated	Eligible expenses	2016 Excess funding	2015 Excess funding
	$	$	$	$
Central West LHIN	**1,173,704**	**912,074**	**261,630**	21,580
Allocation to Other LHIN's				
Central LHIN	**406,000**	**406,000**	-	16,882
Central East LHIN	**406,892**	**406,892**	-	25,000
Toronto Central LHIN	**440,000**	**440,000**	-	-
Mississauga Halton LHIN	**239,935**	**239,935**	-	47,636
North Simcoe Muskoka LHIN	**393,469**	**384,803**	**8,666**	-
Total Other LHINs	**1,886,296**	**1,877,630**	**8,666**	89,518
Total All LHINs	**3,060,000**	**2,789,704**	**270,296**	111,098

c) The amount due to the MOHLTC at March 31 is made up as follows:

	2016	2015
	$	$
Due to MOHLTC, beginning of year	**214,830**	412,446
Funding repaid to MOHLTC prior year	-	(412,446)
Funding repayable to the MOHLTC related to current year activities (Note 3a and 3b)	**409,341**	214,830
Due to MOHLTC, end of year	**624,171**	214,830

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2016	2015
	$	$
Balance, beginning of year	**38,348**	60,909
Capital contributions received during the year	-	51,037
Amortization for the year	**(21,336)**	(73,598)
Balance, end of year	**17,012**	38,348

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment ending in 2018. Lease renewals are likely. Minimum lease payments due over remaining term of existing leases are as follows:

	$
2017	253,270
2018	250,881

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2016. Minimum funding for HSPs related to the next two years, based on the fiscal 2016 accountability agreements, and are as follows:

	$
2017	871,027,048
2018	871,027,048

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

			2016	2015
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	284,229	284,229	-	-
Computer equipment	111,214	94,202	17,012	34,025
Leasehold improvements	712,468	712,468	-	4,323
	1,107,911	1,090,899	17,012	38,348

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the statement of operations reflect the final budget at April 30, 2015. The figures have been reported for the purposes of these statements to comply with PSAB reporting standards. During the year, the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $883,840,336 is made up of the following:

	$
Initial HSP funding budget	857,175,523
Adjustment due to announcements made during the year	26,664,813
Total HSP funding budget	883,840,336

8. Budget figures (continued)

The total operating budget, excluding HSP funding, is made up of the following:

	$
Initial budget	
LHIN Operations	**4,181,828**
Aboriginal Funding	**7,500**
French Language Services	**106,000**
Diabetes Regional Co-ordination	**839,175**
ER/ALC Performance Lead	**100,000**
Adjustment due to announcements made during the year	
ED LHIN Lead	**75,000**
Critical Care Lead	**75,000**
eHealth - Enabling Technologies for Integration	**3,060,000**
One-time transfer	**(40,000)**
Primary Care Lead	**75,000**
Total budget	**8,479,503**

9. Transfer payments to HSPs

The LHIN approved transfer payments to the various sectors in 2016 as follows:

	2016	2015
	$	$
Operation of Hospitals	**533,150,756**	534,196,463
Grants to compensate for Municipal Taxation - Public Hospitals	**96,975**	96,975
Long-Term Care Homes	**158,625,567**	154,298,662
Community Care Access Centres	**115,820,159**	111,366,340
Community Support Services	**15,348,273**	13,956,703
Assisted Living Services in Supportive Housing	**10,608,350**	9,852,612
Community Health Centres	**12,182,882**	12,349,275
Community Mental Health Addictions Program	**37,883,405**	34,726,783
	883,716,367	870,843,813

10. Project Initiatives

The Central West LHIN received funds for various project initiatives listed in the Statement of Operations. The following table classifies the project initiative expenses by object:

	2016	2015
	$	$
Salaries and benefits	**1,322,555**	1,355,470
Professional services	**463,746**	366,008
Shared services	**110,756**	94,468
Occupancy	**46,232**	35,354
Public relations and community engagement	**7,154**	36,988
Supplies	**47,460**	9,832
Other	**87,073**	17,709
	2,084,976	1,915,829

Diabetes strategy operational expenses included in the project fund expenses above are as follows:

	Actual 2016	Actual 2015
	$	$
Salaries and benefits	**572,255**	590,443
Others	**175,600**	138,074
	747,855	728,517

Enabling Technologies for Integration Project Management Office expenses included above include both project management office and Central West LHIN expenses as follows:

Project Management Office expenses are as follows:

	Actual 2016	Actual 2015
	$	$
Salaries and benefits	**479,542**	478,371
Others	**75,848**	66,862
	555,390	545,233

* Prior Year PMO costs where distributed to the contributing LHIN's

Central West LHIN e-Health Enabling Technologies project expenses are as follows:

	Actual 2016	Actual 2015
	$	$
Salaries and benefits	**153,768**	148,104
Others	**202,916**	66,198
	356,684	214,302
Total E-health Enabling Technologies expenses for the Central West LHIN	**912,074**	759,535

11. General and administrative expenses

The statement of operations presents expenses by function. The following classifies these same expenses by object:

	2016	2015
	$	$
Salaries and benefits	**2,997,096**	2,908,190
Occupancy	**170,816**	234,811
Amortization	**21,335**	73,598
Shared services	**283,166**	328,153
LHIN Collaborative	**35,242**	39,018
Consulting services	**152,875**	75,143
Professional Fees	**21,592**	25,716
Supplies	**107,681**	119,509
Board Chair remuneration	**33,925**	48,300
Board member remuneration	**54,089**	57,600
Board expenses	**36,661**	50,353
Mail, courier and telecommunications	**43,681**	41,032
Other	**170,732**	156,288
	4,128,891	4,157,711

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 33 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2016 was $356,706 (2015 - $341,754) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2015. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

Notes...

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ISSN 1913-5718

The Central West LHIN Annual Report 2014/15 is available in both English and French.